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For the Report on the Special Populations Program

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EXECUTIVE SUMMARY

The purpose of this report is to summarize the progress achieved in serving Special Populations clients over the past year and to provide information on the operation of the Special Populations Program. The term “Special Populations” is applied to youth formerly known as “Willie M.” The key highlights of this year’s report are:

The number of Special Populations children continues to grow.

- The number of currently eligible Special Populations children grew to 1,660 at the close of 1999. This represents a 4 percent increase from the prior year and a 55 percent increase over the last seven years. As children are entering the class at a slightly earlier age, the time they remain in the class has increased. This factor has contributed 16% to the increase. Due to continued growth in the number of children in North Carolina and key social trends, further growth in the number of clients is expected.

Special Populations children continue to be very *high-risk* children, although they are acquiring more *protective factors* to help them cope with the numerous risks present in their lives.

- Evidence from a variety of evaluative measures continues to show that Special Populations members are very *high-risk* children with respect to their ability to function normally in society, now and in the future. On average, current Special Populations children have been identified as having 15 different “risk factors” which predict poor outcomes later in life at the time they entered the program. Research has shown that the presence of four or more risk factors places a child at “high-risk” for poor results later in life.
- “Protective factors” help lessen the effects of risk factors by providing a strong base which allows them to avoid poor outcomes such as criminal involvement, mental illness, and substance abuse. Special Populations children who have been in the program through at least two formal evaluations have averaged adding 7 new protective factors for an average total of 20. Progress is particularly evident in the areas of social skills and social support.

The average cost of serving a Special Populations child has leveled off at just over \$50,000 per year.

- Total expenditures for the Special Populations program totaled \$91.2 million in Fiscal Year 1998-99. Of this total, \$6.9 million was granted to local schools by the Department of Public Instruction (DPI), \$80.6 million provided treatment services through the Department of Health and Human Services (DHHS), and the remaining \$3.7 million covered state administration, program evaluation, and training activities.
- The statewide-adjusted average cost of DHHS treatment services per child was \$50,133 in Fiscal Year 1998-99. This was two percent lower than the previous year's adjusted cost. The costs are adjusted to account for the fact that many clients are only in the program for part of the year because they are newly certified or age out when turning 18. As in previous years, costs per child varied significantly, with eleven percent of all clients costing over \$100,000 per child and over forty-seven percent costing less than \$25,000 per child. These differences are caused by the need for much more intensive services, especially residential services, for some clients.

Special Populations children are making progress toward improved functioning in the community. Assessment of new data collected in the last few years shows promising results.

- As a result of client outcome monitoring implemented over the last several years, we now have better information on the progress of Special Populations children. Evaluation shows that Special Populations clients are making progress in all six of the major life domains studied: Residential, Health, Behavioral, Social, Educational, and Legal. Progress appears most evident in moving children to less restrictive residential settings, reducing violent or aggressive behavior, reducing contact with legal agencies, and keeping Special Populations clients in school. The progress appears lasting and greater the longer children are in the program. Finally, progress is greatest for those children who enter the program with the worst problems.

SECTION ONE

HISTORY AND OBJECTIVES OF THE SPECIAL POPULATIONS PROGRAM

This report provides an overview of the purpose, history, and objectives of the Special Populations Program. More importantly, this report addresses the specifics of Special Populations operations and describes the progress being achieved in serving this special population of clients. The focus of this section is:

- the purpose and structure of the report;
- a brief history of the Special Populations Program;
- an explanation of how a child becomes a Special Populations client;
- the goals of the program for individual clients; and
- the management of the Special Populations Program.

A. Purpose and Structure of This Report

This report is meant to apprise the Governor, the General Assembly, and the general public of the efforts being made to serve the special needs of the Special Populations children, formerly known as Willie M. This report has been prepared annually since 1984 to provide detailed and specific information on how the Special Populations program is meeting its responsibilities.

The report describes the Special Populations Program, the children being served, the services provided, the costs of those services, and progress being achieved by the children. It is sub-divided into five sections.

- **Section 1** presents a **brief overview** of the program with comment on its history, objectives, and management.
- **Section 2** characterizes the **clients being served** and includes data presentations related to numbers of clients, their demographics, and psychosocial conditions.
- **Section 3** describes the in-place **service system** and comments on its design.
- **Section 4** reports program operation **costs** and shares information on averages and high-cost children.
- Finally, **Section 5** summarizes important information about the **progress** and status of Special Populations children with regards to basic objectives for improving their ability to function in society.

B. Brief History of the Special Populations Program

Willie M. was one of four children for whom a class action lawsuit was filed in October 1979. The plaintiffs, all minors, sought the right to receive treatment and educational services that had repeatedly been denied. Because these children had a history of violent behavior and mental or emotional handicaps, they were often blocked from entering, or asked to leave, programs that were not really designed to meet their needs. After repeated, unsuccessful efforts by attorneys, mental health professionals, judges, and others to obtain services, the plaintiffs concluded that the State of North Carolina would continue to deny services to these children for whom both federal and state laws guaranteed education and related treatment services.

In the lawsuit, the plaintiffs defined the children they were representing as every North Carolina citizen under 18 who fits all of the following:

- now, or will in the future, suffer from serious emotional, mental, or neurological handicaps;
- exhibits violent or assaultive behavior;
- is, or will be, involuntarily institutionalized; and
- is not receiving appropriate treatment and education services.

The defendants were State government officials, including the Governor, the Secretary of the Department of Human Resources¹, the State Superintendent of Public Instruction, and the Chairman of the North Carolina Board of Education.

In September 1980, both parties worked out a settlement in which the Defendants agreed to identify and provide appropriate services to all children meeting the criteria stated in the lawsuit. The Federal Court established a Review Panel to monitor and oversee the State's implementation of the Consent Decree.

During the ensuing years, the involved State agencies, with the assistance of the General Assembly, established a program of services across North Carolina to serve class members. The 1995 General Assembly enacted legislation [N.C.G.S. 122C-3(13a)] defining clients eligible for Willie M. services in a manner consistent with the definition in the original lawsuit. In addition, legislation authorized DHR to adopt rules governing determination of eligibility for services, ensuring provision of services and providing for

¹ The Department of Health and Human Services (DHHS) was newly named in 1997. Prior to this time the name was the Department of Human Resources (DHR). The latter name is used in this report when it refers to actions taken place before 1997.

contested case hearings [N.C.G.S. 122C-194-200]. These actions by the General Assembly were made in an attempt to enable the State to assume complete responsibility for the operation of the Willie M. Program without continued oversight by the Federal Court. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services implemented the rules, effective March 1, 1997 [N.C. Administrative Code T10: 14V.7000] which covered:

- Detailed eligibility criteria for services;
- Application and eligibility determination procedures;
- Needs assessment, service planning and service provision requirements;
- Area program and Division requirements;
- Procedures for providing prior notice to parents of proposed changes in the service plan or services;
- Procedures for responding to and resolving disputes about a child's needs assessment, service plan or services (including the availability of third party mediation, the right to file a petition for a contested case hearing, and administrative review by a departmental review officer).

Shortly after passage of the new statute, the Department of Human Resources adopted Administrative Rules for the administration of the Willie M. Program. These two actions allowed the State of North Carolina to make a Motion to the Federal Court in January 1997 that the Court find the State in compliance with the directives of the Court and dismiss the case, thus ending the need for continued oversight.

On January 22, 1998, Judge Graham Mullen ordered the dismissal of the Willie M. Consent Decree and lawsuit. Judge Mullen found that the State's program of services for Willie M. class members complied with the Court's Decree "to the extent practicable." He further found that changes in law, since the Consent Decree was signed in 1980, removed the basis for Federal Court jurisdiction in the case. While noting that change in federal law removes this case from federal jurisdiction, Judge Mullen emphasized the State's obligations to serve these children under State law. He noted that the statute remains subject to enforcement by State Courts.

The end of the lawsuit did not mean the end of the State's commitment to identify and serve children and adolescents with serious mental, neurological, or emotional disabilities accompanied by violent or aggressive behavior. It simply means that the State now exercises its responsibilities to serve these children without the oversight of the Federal Court. Children with service needs continue to reside across the State of North Carolina. Prior to

the intervention of the Federal Court these children were shuffled off to training schools, state hospital wards, or inappropriate home placements with little or no attention given to their unique problems and disabilities. Today an integrated system of care is in place, and these children are appropriately served.

C. How Children Become Special Populations Clients

Anyone who knows a child and is familiar with his/her problems may request that the child be considered for Special Populations services. A nomination/application form is usually submitted to the child's area mental health center where staff assist with completion of the application form, obtain consent form signatures, and gather supportive documentation.

Since Special Populations Program participation is voluntary, the child's parent or legal guardian must provide consent before a child can be found eligible for services. The child's application will be halted if consent is withdrawn at any time during the eligibility process. Once the parent or guardian grants consent and the information necessary to demonstrate the child's need for services is collected, the application is sent to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, (DMH/DD/SAS) Child and Family Services Section in Raleigh for a determination of eligibility. Division staff, with the assistance of contracted specialists, review the application and render a decision on eligibility. If the child meets all eligibility criteria, the child is determined eligible for services and notifies all relevant parties of the decision. The Area Mental Health, Developmental Disabilities and Substance Abuse Program (Area Program) staff quickly begin the treatment planning process in order to assure the delivery of appropriate services.

If the child does not meet all of the criteria, the application/ nomination is not accepted, and all parties are notified of this decision and the reasons for it. If the applying party or the parent/guardian has additional information to offer in support of the nomination, the application may be reactivated on their request. The State staff will reconsider the application, render a decision, and notify all parties of the decision. If the applying party disagrees with the decision, he/she may appeal the decision through the Program's Contested Case Hearing Process.

The application process has remained essentially the same throughout the history of the program. Since 1981, nearly 11,000 children have been nominated for program membership and more than 6,000 have been found eligible as clients.

D. Program Goals for Individual Clients

The Special Populations Program does not guarantee a “cure” to children accepted for services. Rather, the State agencies with responsibility for these children have always attempted to design and deliver services that have positive long-term impacts on a child’s functioning.

Following this reasoning the General Assembly directed DHR and DPI in 1992 to develop a plan to achieve compliance with the lawsuit and to collect and report on whether Willie M. children made progress while receiving services. Along with an overall plan for achieving compliance, DHR and DPI developed a statement of desired outcomes for Willie M. clients at age 18. Although no one can guarantee successful outcomes for all of these children, the State adopted the following service goals:

- Education - The client attends and participates in educational services appropriate to his/her needs.
- Health - The client will, to the extent that he/she is able, maintain a state of health sufficient for his participation in normal, productive, and rewarding activities.
- Housing/Residential - The client has a “home,” even if it is not his/her natural home, which provides him/her with a safe, nurturing environment conducive to the achievement of all of his/her other goals and objectives.
- Social - The client has at least one person who is also an advocate, friend, and confidant who maintains a long-term relationship with the child, fostering trust, self-esteem, and social competence.
- Vocation - The client is engaged in meaningful employment in a real work setting of his/her choice, or in activities leading toward that goal.
- Behavior - The client develops the social competence and coping skills he/she needs in order to reduce or ameliorate assaultive and aggressive behaviors.

In 1994, DHR began collecting simple measures of current functioning among Willie M. clients and has collected the same information on all certified clients since then. Starting in 1995, DHR began annual formal assessments of each child’s current functioning, as well as an inventory of the conditions and experiences which put the child *at-risk* for poor outcomes in life as well as *protective factors* which might reduce such poor outcomes. Results from these ongoing assessment activities are presented in Section 5 of this report.

E. Management of the Special Populations Program

The Special Populations Program now encompasses over 1,600 active clients, \$91.2 million in State and federal funding, and thousands of people working full or part time all over North Carolina to serve this very difficult population. The management of this large and complex endeavor is based on a commitment to quality, efficiency, and results. All associated agencies have invested significant resources in quality improvement efforts so that they may ensure that public funds are spent in ways that provide the maximum opportunity for clients to heal, develop, and progress into productive adulthood.

The quality improvement philosophy under which the program is managed requires that a variety of data collection and monitoring activities be conducted on a continuous basis. The purpose of these activities is to learn as much as possible about the problems our clients face, the services they receive, the costs of those services, the outcomes they achieve, and the factors associated with good or bad outcomes. These types of findings enable program staff to adjust service packages, clinical practices, organizational and financial arrangements, training needs, and other aspects of the system to better serve the client.

Because the Special Populations Program has always maintained a focus on the individual child, his/her particular needs, and his/her service planning, much of the DMH/DD/SAS monitoring system is directed toward collecting data on the individual child's needs, the services being provided, and the outcomes achieved. In order to achieve the best outcomes for all children and in order to ensure cost-effective service provision, the program staff must also monitor how whole systems of services perform for large groups of clients. This causes the Special Populations Program to prepare aggregate statistics on children, services, and expenditures. Additionally, DMH/DD/SAS monitors the performance of local agencies involved in and supporting the delivery of Special Populations services. Moreover, DMH/DD/SAS monitors trends in demographics, social problems and service practices in the larger human services world and general society. The system monitoring results are used to design service system improvements and enhance clinical knowledge and practice approaches. In addition, the results are relied upon to report to the general public, as it is this group to whom the system is ultimately accountable.

SECTION TWO

DESCRIPTION OF SPECIAL POPULATIONS CLIENTS

This section of the report describes the more than 1,600 children across North Carolina who have qualified as Special Populations clients. It includes specific information on:

- the number of clients served,
- the demographic characteristics of the clients,
- the psychosocial characteristics of the clients, and
- the reasons for the growth in the number of Special Populations clients.

A. Number of Special Populations Clients

The number of Special Populations clients has been growing. As of December 31, 1999, there were 1,660 eligible Special Populations clients. This represented an increase of four percent over the previous year-end total. TABLE 1 shows the number of certified eligible children by calendar year as well as the number of new applications and new determinations of eligibility. The number of children currently eligible has been growing over time with most of the growth occurring in the last seven years, a 55 percent increase in currently eligible members since 1992. Because of the importance of this growth and its connection to other changes in program membership, the issue of growth is discussed in greater detail later in this section of the report (See Section D, page 25).

TABLE 1 HISTORY OF NOMINATIONS, CERTIFICATIONS, AND ELIGIBLE CLIENTS BY CALENDAR YEAR			
Period Ending	Number Nominated	Number Newly Certified	Number Certified Eligible Clients End of Period
Through			
1982	2,572	1,074	982
1983	609	280	1,073
1984	466	280	1,099
1985	451	256	1,095
1986	478	240	1,080
1987	360	195	1,052
1988	393	215	1,022
1989	464	268	1,069
1990	477	208	1,037
1991	459	218	1,034
1992	426	274	1,070
1993	456	357	1,202
1994	391	214	1,189
1995	494	333	1,244
1996	640	395	1,408
1997	604	437	1,523
1998	536	354	1,598
1999	533	373	1,660

Applications and determinations of eligibility for services have also been increasing over time, although both are below their peaks from several years ago. There were 533 children newly nominated during 1999—roughly even with the prior year--and 373 were newly certified as eligible for services during the same period—an increase of 5 percent from the prior year. Over the past ten years the number of applications has increased by 15 percent. The number of certifications of eligibility has climbed significantly, increasing by 39 percent in the same ten-year period.

The number of Special Populations children being served in public schools has followed the same pattern of growth. The Department of Public Instruction is responsible for ensuring that Special Populations clients receive appropriate educational services. These services are also provided in accordance with federal and state law governing programs for exceptional children. The vast majority of Special Populations students are classified as exceptional children and receive special education and related services through Local Educational Agencies (LEA).

A periodic headcount is conducted as a partial means of monitoring the educational services being provided in local educational agencies to program clients. The number of Special Populations children being served by LEAs as of June 15, 1999, was 1,398, a two percent increase over the prior year (see TABLE 2). The number of program clients being served by LEAs is always less than the total number of clients because some children are being served in other educational settings such as state institutions, and others are no longer in school. The number of clients being served by local school systems shows the same upward trend as the entire program population over time, although it is increasing faster, up 91 percent in the last seven years. The reason for this faster increase is the greater proportion of Special Populations clients now being served in the public schools. In 1992, approximately 68 percent of the certified clients were in public schools, while in 1999 the number had climbed to 84 percent. Keeping program clients in school is one of the important goals for the Program.

TABLE 2 NUMBER OF CHILDREN SERVED AND LOCAL EDUCATION AGENCIES (LEAs) PROVIDING SERVICE		
Period Ending June 15 th	Number of Clients Served by LEAs	Number of LEAs Providing Services
1991	770	100
1992	731	98
1993	853	104
1994	970	98
1995	1,008	99
1996	1,117	96
1997	1,205	102
1998	1,366	95
1999	1,398	105

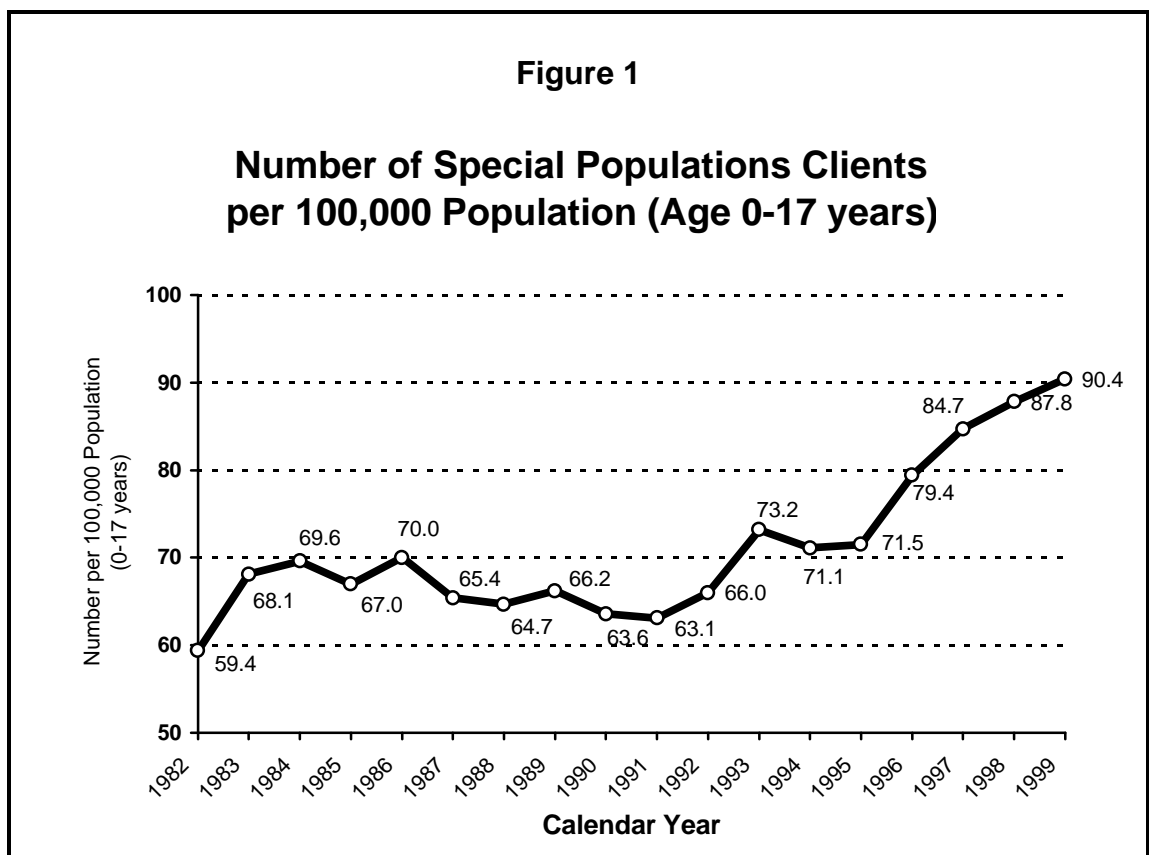
B. Demographic Characteristics of Special Populations Clients

While the number of Special Populations clients has been increasing, the demographic characteristic of those being served has remained relatively stable over time. Program clients come from across the state and are predominantly teenage males.

1. Frequency of Special Populations Children in the General Population

The number of Special Populations children is fairly small when compared to the child population as a whole. With 1,660 program clients at the end of 1999, this is only 0.09 percent of the child population aged 0-17 in North Carolina, or roughly one Special Populations child for every 1,100 children in the State.

The number of Special Populations children relative to the population has been increasing. FIGURE 1 shows the number of currently eligible Special Populations children in North Carolina per 100,000 children by year since the Program's start. While the rate remained relatively stable in the early years, the frequency has noticeably increased in the last few years. Before 1993, the



rate never exceeded 70 Special Populations clients per 100,000 population. But, since that time it has not been below this level. The increase in the rate from 66.0 in 1992 to 90.4 in 1999 is thirty-seven percent. This increase is caused in large part by a growing number of applications and determinations of eligibility and by children being found eligible for services at a younger age. The younger the age at eligibility, the longer the time of program connected support.

2. Distribution of Special Populations Clients across North Carolina

Children being served by the Special Populations Program can be found all across the State. TABLE 3 shows the number of program clients who were eligible to receive services at the end of 1999 by their home area mental health program. The table also shows the frequency of eligible clients relative to the total child population in the respective areas.

Standardizing rates of certification per 100,000 population under 18, provides a perspective on how local catchment areas compare to one another. In particular, relative participation in the Special Populations Program for each local mental health catchment area can be measured against the state average listed in the last line of the table. There is a large range about the state average. Rutherford-Polk, the area program with the highest rate in 1999, had a rate of participation relative to the youth population six times higher than the lowest area, Roanoke-Chowan. Differences are probably due to a combination of referrals, local administrative operation, and social demographics, but examination of the participation rates has not revealed a clear pattern that would explain the variation. Area programs with the highest number of active certified children relative to the population include Rutherford-Polk, Vance-Granville-Franklin-Warren, Smoky Mountain, Trend, Foothills, Wayne, and Rockingham. Areas with particularly low rates compared to the state include Roanoke-Chowan, Onslow, Albemarle, and Mecklenburg.

It is worth mentioning that although some local area programs have high rates and others low ones, many programs have wide variations in their certification rates across time. This variation is more a reflection of relatively small numbers of clients in some local programs and of organizational and administrative changes within the local systems rather than changes in the characteristics of their youth population. For example, in service composition in mental health and educational areas may account for fluctuations of certification rates over time.

TABLE 3 LOCATION OF CERTIFIED ELIGIBLE SPECIAL POPULATIONS CLIENTS BY AREA MENTAL HEALTH PROGRAM AS OF DECEMBER 1999		
Area Program	Certified Eligibles as of December '99	Eligibles per 100,000 Population, Age 0-17
<i>Eastern Region</i>	269	70.6
Albemarle	11	40.1
Duplin-Sampson-Lenoir	20	50.9
Edgecombe-Nash	20	52.6
Halifax	9	57.4
Neuse	28	70.3
Onslow	16	38.9
Pitt	24	77.2
Roanoke-Chowan	6	31.8
Southeastern-Central	61	106.1
Tideland	15	66.1
Wayne	38	135.1
Wilson-Greene	21	97.2
<i>North Central Region</i>	406	100.0
Alamance-Caswell	28	87.0
Centerpoint	66	76.1
Crossroads	52	104.4
Durham	50	100.8
Guilford	67	74.3
Orange-Person-Chatham	46	115.5
Rockingham	27	130.0
Vance-Granville-Franklin-Warren	70	189.5
<i>South Central Region</i>	384	82.2
Cumberland	63	72.7
Davidson	34	100.7
Johnston	22	83.8
Lee-Harnett	38	112.5
Randolph	26	86.7
Sandhills	54	111.1
Southeastern Region	69	107.5
Wake	78	54.2
<i>Western Region</i>	601	103.2
Blue Ridge	61	113.9
Catawba	30	96.5
Foothills	76	144.0
Gaston-Lincoln-Cleveland	94	114.4
Mecklenburg	73	45.8
New River	20	67.2
Piedmont	119	115.9
Rutherford-Polk	35	198.5
Smoky Mountain	60	188.7
Trend	33	154.4
<i>Entire State</i>	1,660	90.4

3. Age of Special Populations Clients

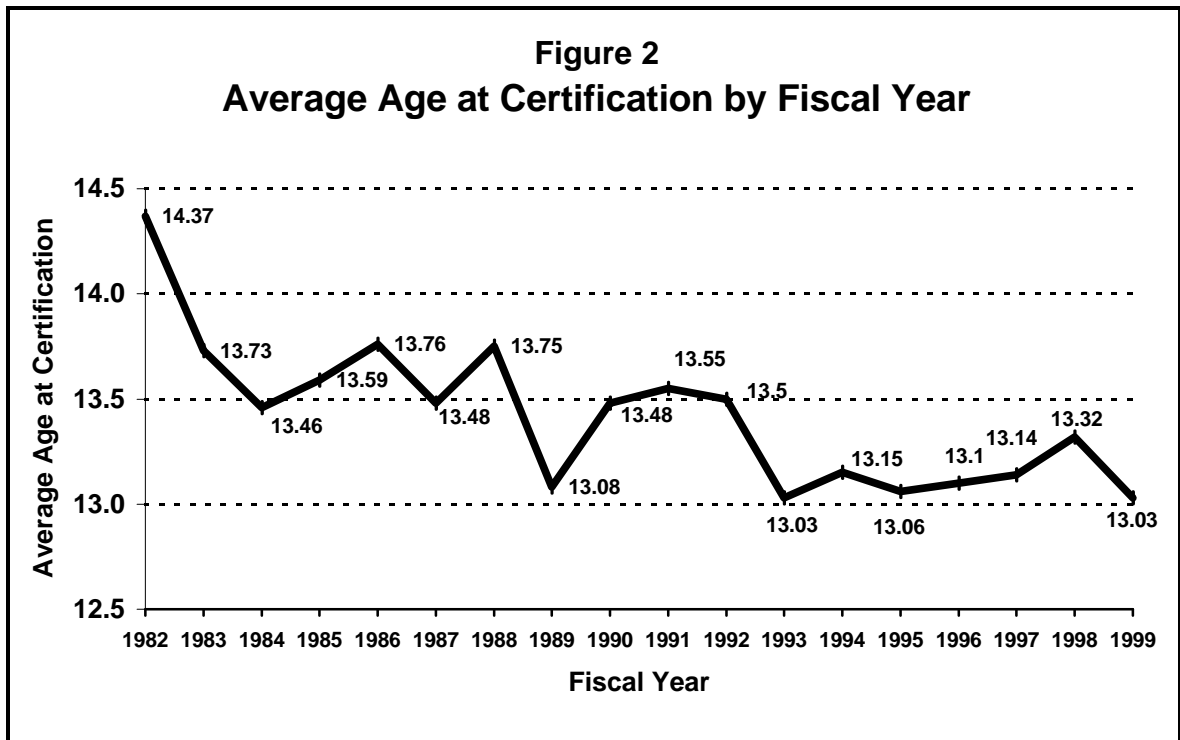
Most Special Populations clients are teenagers. The average age of children in the Program at the end of 1999 was 14.8 years. However, it is very important to understand that there is a wide range in the ages of Special Populations clients. The youngest client at the end of 1999 was four years old. The oldest client was age eighteen. While children in the Program generally are removed from the active list at their 18th birthday, some remain as clients past this time if they are near completion of school or other services. TABLE 4 shows the distribution of Special Populations clients by their age. It is important to recognize that a large number of Special Populations clients are quite young. One-fourth of the Program's clients are 12 years of age or younger.

TABLE 4 AGE DISTRIBUTION OF SPECIAL POPULATIONS CHILDREN AS OF DECEMBER 1999		
Age	Number	Percent of Total
4	1	0.1
5	1	0.1
6	4	0.2
7	12	0.7
8	24	1.4
9	41	2.5
10	67	4.0
11	85	5.1
12	123	7.4
13	188	11.3
14	198	11.9
15	266	16.0
16	300	18.1
17	313	18.9
18	37	2.2
Total	1,660	100.0%

The average age of Program clients has remained relatively stable over time. However there is a modest trend in younger children being admitted to the Program. FIGURE 2 shows the average age of newly eligible children for each year the Program has been operating. For the most recent fiscal year, the average age at the time of eligibility determination was 13.03. Over the course of the Program, the average age at certification has ranged from a high of 14.37 years for the first period recorded (FY82) to the current year low of 13.03 (also FY93).

Examination of FIGURE 2 shows a trend of a modest decline in the average age at eligibility for services. Excluding the first year, which was unusual due to factors associated with Program startup, the average age has declined from 13.73 in FY83 to 13.03 in FY99. While this difference is only 0.7 years, the effect on the number of children in the Program is noticeable. For FY83 the average child could have been expected to stay in the Program 4.27 years, while children entering in FY99 would be expected to remain in the Program 4.97 years on average. This small difference would have the effect of increasing the total number of children being served at any given time by approximately sixteen percent, all other things being equal. The identification of younger children is desirable because it allows for earlier and longer provision of services to clients with, what is hoped, more positive outcomes. It

seems likely that given the eligibility requirements of violent behavior, the average age should probably not drop significantly further.



4. Grade Placement in Public Schools for Special Populations Children

The distribution of Special Populations clients across public school grade levels reflects a range from day care up to the 12th grade as would be expected given the wide range of ages for Program clients. The average placement for these children is eighth grade. Most clients are either in junior high or high school (see TABLE 5). However, more than one-fourth of the clients are in grade school or below. Ungraded children are clients who are severely impaired

TABLE 5
GRADE PLACEMENT AS OF JUNE 15, 1999

Grade Level	Number	Percent of Total
Day Care	4	0.3
Kindergarten	11	0.8
1	17	1.2
2	36	2.6
3	68	4.9
4	63	4.5
5	78	5.6
6	145	10.4
7	179	12.8
8	223	16.0
9	276	19.7
10	181	12.9
11	78	5.6
12	11	0.8
Ungraded	28	2.0
Total	1,398	100.0%

and are not classified into a grade level because of the impairment. Grade level placement information was unavailable for two of the children.

5. Race of Special Populations Clients

The racial distribution of eligible clients has remained relatively stable over time with the percentage of white members hovering just over half of the total clients in the Program at any given time. At the end of 1999, whites represented 57 percent of all Special Populations clients. African-Americans comprised 38 percent of clients, and other ethnic groups represented the remaining 5 percent. In any given year the proportion of newly eligible children will vary, but this pattern has been fairly consistent.

6. Gender of Special Populations Clients

The Program has always had an overwhelming predominance of males. At the end of 1999, males comprised 81 percent of the Program client population. This percent has remained relatively stable over time with males generally representing 80 to 85 percent of the total client group in most past years. The preponderance of males is clearly a function of the criteria for eligibility, which include behaviors that are traditionally associated with males, such as aggressive behaviors.

C. Clinical and Psychosocial Characteristics of Special Populations Clients

The single most important fact to understand about Special Populations children is that they are a population with significant emotional, psychological, and social problems and are facing substantial obstacles to normal functioning in society. Indeed, by a variety of different measures, Special Populations clients are very *high-risk* children. The needs of Program clients are correspondingly much higher than most other clients and their prognosis much less certain.

1. Clinical Characteristics

It is clear from statewide data that Special Populations clients, as a group, have much more severe problems and more seriously impaired functioning than most other North Carolina children who come to area mental health programs for services. DMH/DD/SAS requires that all children served by Area Programs be assessed for overall global functioning on a standardized clinical instrument, the Child and Adolescent Functional Assessment Scale (CAFAS). A 1996 survey of CAFAS scores revealed an average score of severity of 92.7 for Special Populations youth, compared to a score of 47.8 for non-Special Populations youth that used mental health

services in North Carolina. However, there are many children outside the Special Populations group with CAFAS scores in this very high range. These are children with severe emotional disturbances that do not express their problems through violent or assaultive behaviors.

Assessment of Special Populations clients shows that most have multiple psychiatric disorders. Four-fifths of all clients had two or more major psychiatric disorders while 42 percent had three or more disorders. The most prevalent psychiatric diagnoses listed for program clients (counting multiple diagnoses) were:

- Attention Deficit/Hyperactivity Disorder (44 percent),
- Conduct Disorder (43 percent),
- Other Disruptive Behavior Disorders (42 percent),
- Depressive Disorders (19 percent),
- Anxiety Disorders (19 percent), and
- Mental Retardation (19 percent).

Other disorders present in less than 10 percent of Program clients included: Substance Abuse Dependency, Bipolar Disorder, Post-Traumatic Stress Disorder, Adjustment Disorder, Learning Disorder, Psychotic Disorder, Pervasive Developmental Disorder, Other Anxiety Disorders, and Paraphilias.

Given the psychological problems facing Special Populations children, it should not be surprising that they are also classified as having educational handicaps. The Department of Public Instruction collects information about educational handicaps faced by clients. As in previous years, the most common condition is that of Behaviorally/ Emotionally Disabled (BED) with more than three-fifths of all clients being so classified (see TABLE 6). One in every seven (15%) of the Special Populations children in public schools was not identified as having any educational handicap.

2. Psychosocial Risk and Protective Factors

Special Populations clients are *high-risk* children. The literature on *high risk* children identifies a number of psychosocial *risk factors* or negative experiences which seem to substantially increase the likelihood of poor life outcomes in realms of mental illness, socioeconomic status, education, vocational instability, criminal justice involvement, and substance abuse. Previous research has found that the presence of four or more risk factors predicts poor outcomes later in life.

However, not all children with multiple risk factors fail to thrive. There is a subgroup of children who possess *protective factors*, or positive experiences, that allow them to avoid poor outcomes later in life. It is these protective factors, and their ability to play a role in improving functioning for at-risk populations of children, that has given rise to the notion of “resiliency.” As a concept, resiliency theory has broad acceptance as an explanation of why some children go on to lead fairly normal and productive lives even in the presence of great handicaps and obstacles.

A list of risk factors and protective factors consistently identified in the literature and used for assessment in the Special Populations

Program is provided in TABLE 7. These factors are evaluated for all Special Populations children on the Assessment Outcome Instrument (AOI), and can be divided into several conceptual categories: early developmental factors, skills and competencies, social skills, confident attitudes, family factors, and social support network. A major goal of treatment of *high risk* children is to increase their protective factors or positive experiences to allow them to improve themselves.

<p>TABLE 6</p> <p>EDUCATIONAL HANDICAP CLASSIFICATION</p> <p>AS OF JUNE 15, 1998</p>		
Primary Handicapping Condition	Number	Percent of Total
Academically Gifted (AG)	8	0.5
Autistic (AU)	11	0.8
Behaviorally/Emotionally Disabled (BED)	859	61.4
Educable Mentally Handicapped (EMH)	102	7.3
Hearing Impaired (HI)	12	0.9
Multihandicapped (MU)	10	0.7
Orthopedically Impaired (OI)	2	0.1
Other Health Impaired (OHI)	54	3.9
Preschool-Developmentally Delayed (PD)	4	0.3
Severe/Profound Mentally Handicapped (S/P)	2	0.1
Specific Learning Disabled (SLD)	86	6.2
Speech-Language Impaired (SLI)	2	0.1
Trainable Mentally Handicapped (TMH)	26	1.9
Traumatic Brain Injury (TB)	9	0.6
Not Identified as Handicapped	211	15.1
Total	1,398	100.0%

TABLE 7
PSYCHOSOCIAL RISK AND PROTECTIVE FACTORS

<u>Risk Factors</u>	<u>Protective Factors</u>
<p><i>Early Developmental</i> Premature birth or complications Fetal drug/alcohol effects Long-term absence of caregiver in infancy Poor infant attachment to mother Shy temperament Siblings within 2 years of child Developmental delays "Difficult temperament"</p> <p><i>Childhood Disorders</i> Repeated aggression Delinquency Substance abuse Chronic medical disorder Behavioral or emotional problems Low IQ < 70</p> <p><i>Parental Disorders</i> Parent with substance abuse Parent with mental disorders Parent with criminality</p> <p><i>Family Stress</i> Family on public assistance or Living in poverty Separation/divorce/single parent Large family, 5 or more children Frequent family moves</p> <p><i>Experiential</i> Witness to extreme conflict/violence Removal of child from home Substantiated neglect Physical abuse Sexual abuse Negative relationship with parent(s)</p> <p><i>Social Drift</i> Academic failure or drop-out Negative peer group Teen pregnancy, if female</p>	<p><i>Early Developmental</i> "Easy temperament" Positive attachment to mother Independence as a toddler</p> <p><i>Child Competencies</i> Reasoning and problem solving skills Good student Good reader Child perception of competencies Extracurricular activities or hobbies IQ > 100</p> <p><i>Family</i> Lives at home Parent(s) consistently employed Parent(s) with high school degree or better Other adults or children to help with childcare Regular Involvement with religious organizations Regular rules, routines, chores in home Family discipline with discussion and fairness Positive relationship with parent(s) Perception of parental warmth</p> <p><i>Child Social Skills</i> Gets along with other children Gets along with adults "Likeable" child Sense of humor Empathy</p> <p><i>Extra-Familial Social Support</i> Adult mentor outside family Support for child at school Support for child through a religious organization Support for child from faith Support for child from peers</p> <p><i>Outlooks and Attitudes</i> Internal locus of control as teen</p>

2. (a) Psychosocial Risk Factors

Risk factors are traits, characteristics, innate abilities or deficits, and life experiences that increase the chances of poor outcomes later in life. These are factors that have been identified by researchers over the last twenty-five years in studies over time of child functioning. As already noted, research has shown that when a child has four or more of these risk factors present, he/she will probably face significant problems later in life. Based on the most recent assessments done of clients, the average Special Populations child had 15 risk factors when entering the program, placing this group of children at extremely high risk for poor life outcomes.

Certification requirements mandate that all Special Populations children have the risk factors of behavioral aggression and emotional/mental disorder at the time of initial eligibility. Review of the data reveals that about half of the Program clients had aggressive behavior noted in preschool years, while over 90 percent had developed aggression by the time they reached school age. Listed below is information on the prevalence of the most common risk factors among Special Populations clients as a group.

The early development of Special Populations children is marked by adversity.

- 48.2 percent had neurological impairment or developmental delays

Special Populations children have had significant negative experiences past infancy.

- 93.3 percent have witnessed extreme conflict or violence
- 90.9 percent have negative relationships with one or both parents
- 87.8 percent have been removed from their homes at some point
- 73.0 percent have been documented as being physically abused
- 45.6 percent have experienced substantiated neglect

Most clients come from extremely stressed families.

- 91.5 percent come from single parent, divorced, or separated families
- 91.1 percent of the children come from families living in poverty
- 67.2 percent of the families made frequent moves
- 46.0 percent had siblings born within two years

Most Special Populations children have parents with considerable problems themselves.

- 76.8 percent have parents with mental disorders

- 75.3 percent have parents with substance abuse problems
- 55.7 percent have parents with some criminal involvement

Special Populations children experience “social drift” (that is, entering and leaving negative social environments).

- 68.0 percent have experienced academic failures or dropouts
- 62.0 percent reported negative peer groups when they became a client or since entering the program

Special Populations children have numerous childhood disorders.

- 100 percent have a problem with repeated aggression
- 99.7 percent have behavioral or emotional problems
- 98.9 percent have been in trouble with the law

It is clear that the Special Populations clients represent a very troubled group of children. While many of these risk factors cannot be eliminated, focusing on the development of protective factors may allow these troubled children to build a base of stability that provides the capacity to overcome the difficulties they have faced.

2. (b) Psychosocial Protective Factors

Protective factors are specific characteristics of a child or aspects of the child’s history, family life, and social support network, which studies have shown confer protection against poor outcomes in high-risk youth. Studies of resiliency in certain high-risk youth suggest that the extent to which a child possesses these positive qualities or experiences offers the possibility of averting common undesirable outcomes, including mental illness, school drop-out, vocational instability, criminal involvement, substance abuse and social dysfunction. Based on the most recent assessments of Program clients, the average Special Populations child had 13 protective factors upon entering the Program, but after being in the program for a few years, the average number of protective factors has increased significantly to 20.

Because of the importance of protective factors for fostering resilience or the ability to overcome risk factors, adding protective factors for children has become a key focus of treatment plans with obvious success thus far. This net increase in positive factors should increase the likelihood that these children will overcome or cope with their difficulties. Listed below is information on the current prevalence of the most common protective factors among Special Populations clients who have been in the Program at least one year. Information is also provided about the number and nature of added protective factors since these clients started the Program. Examination of the addition of protective factors among Special Populations clients reveals

marked improvement particularly in the areas of social skills and social support outside the family. It appears that for a substantial group of clients, a variety of positive changes have been made.

Self-perception of competency at some activity is nearly 100 percent, though specific competencies are lower. Importantly, substantial improvements in specific competencies have been made since these children entered the Program.

- 99.5 percent of the Special Populations children perceived themselves as being competent at some activity, up 3.3 percent from the start
- 72.8 percent of Special Populations clients showed problem-solving skills, up 31.2 percent from the start
- 70.8 percent of clients engaged in some hobby or extra-curricular activities, up 34.1 percent from when these clients entered the Program
- 39.6 percent were good readers, up 14.7 percent
- 29.2 percent were judged good students, up 18.6 percent

Family support is generally high for Special Populations children with significant increases in all areas since the clients began participation in the Program. Not all of these changes are necessarily a function of participation in the Program but it may be that the Program allows families to make improvements by providing support to the troubled child.

- 96.3 percent of the children feel their parents care, up 13.8 percent
- 93.7 percent had other adults or children help with child care, up 10.7 percent from starting the Program
- 90.2 percent had parents who were consistently employed, up 14.4 percent
- 86.1 percent of the children had fair discipline at home, up 27.1 percent
- 81.4 percent had parents with a high school degree or better, up 18.7 percent from the children's start in the Program
- 77.1 percent of the children came from families with regular rules, routines, and chores at home, up 26.5 percent
- 76.4 percent had positive relationships with their parents, up 23.9 percent
- 51.6 percent of the children were in families with regular church involvement, up 18.7 percent

Social skills for Special Populations children is an area where clients have made the most progress in adding protective factors since entering the Program.

- 87.2 percent of the children are perceived as “likeable,” up 29.9 percent
- 84.8 percent are described as having a sense of humor, up 32.0 percent
- 74.4 percent show ability to get along with adults, up 34.1 percent
- 68.6 percent have shown ability to get along with other children, up 37.5 percent since entering the Program
- 57.3 percent have shown empathy or nurturing behavior, up 34.1 percent

Special Populations clients have also made substantial strides in adding social support outside the child’s family that may be linked to improved social skills. Importantly, about one-third of the children added an adult mentor. Studies of resilient youth suggest that nearly all of those who rose above their risk factors were able to identify some adult mentor figure that was there for them as a refuge and support in times of need.

- 80.9 percent of the children had a positive relationship with someone at school, up 26.6 percent
- 76.7 percent had an adult mentor outside the family, up 28.7 percent
- 62.6 percent had special support from peers, up 29.6 percent
- 61.4 percent had some reliance on inner faith, up 28.7 percent

D. Understanding the Growth in Numbers of Special Populations Clients

Mentioned earlier in this section is the observation that the number of Special Populations Program clients has been growing, particularly over the last six years. Since 1992, the number of children being served at the end of the calendar year has grown by 55 percent. Given the importance of this growth for the operation and funding of the Special Populations Program, it is worth trying to understand why the number of clients has been increasing. Examination of the available information suggests that there are four primary trends at work that may explain most of the growth. Each needs to be considered in turn:

- a growing youth population,
- younger children being found eligible for services,

- greater social problems, and
- greater awareness of the Special Populations Program.

The youth population of North Carolina has been growing. Between the beginning of the Program in 1981 and the end of 1999, the number of children in the state under eighteen years of age has increased by 13 percent (population estimates derived by the State Planning Office). As the number of children in the State increases over time, there should be an expectation that the number of children being served by the Special Populations Program will also increase. Growth in the North Carolina youth population is expected to continue. A further 4 percent increase is anticipated between the years 2000 and 2010. Significantly, the population of North Carolina teenagers, which constitutes three-fourths of the Special Populations clients, will be growing much faster. The state population estimates for children aged fourteen to seventeen project a 13 percent increase between the years 2000 and 2010.

A second trend in place is that younger children are being determined eligible as Special Populations clients. As discussed earlier, the average age at which children become eligible for services has declined slightly over time. Because all clients remain eligible to at least their eighteenth birthday, the effect has been to increase the total number of children being served. From FY83 to FY99, the average age at eligibility determination has dropped from 13.73 to 13.03. This change alone would have the effect of increasing the total number of Special Populations clients by 16 percent.

A third set of trends associated with an increase in the number of Special Populations clients is the rise in social problems as diverse as crime and low-weight births. As already noted in the discussion on risk factors, certain experiences tend to increase the likelihood that a child will be at risk for mental illness, violence, and other forms of social dysfunction. Therefore, if certain social problems increase substantially, we would expect to see subsequent increases in the number of at-risk children such as Special Populations Program clients. For example, the number of violent crimes in North Carolina increased by 75 percent between 1982 and 1995. Since exposure to violence or extreme conflict is an important risk factor, we might reasonably expect to see noticeable increases in at-risk children. Similarly, premature births or complications at birth is another demonstrated risk factor. The number of low-weight births in North Carolina increased by 29 percent between 1982 and 1995. It is important to understand that even if these negative trends were to stop today, the lingering effects would continue to manifest themselves in children already born so that it might be five to ten years before the complete negative impact would register. A reasonable method for estimating how much these negative social trends would affect the specific numbers of at-risk children is not available, but it is clear that given the magnitude of these trends some significant effect should be expected.

The fourth important trend, which helps explain the growth in the Special Populations Program size, is that the Program is receiving more attention and, consequently, more referrals. The Program relies on parents, mental health providers, judges, teachers, and others to refer potential children. Ten to fifteen years ago, the Special Populations Program was still relatively new and not well known. With the passage of time more people have become aware of the Program and its potential to help severely at-risk children. Within the last decade the number of new determinations of eligibility for services in a given year has increased by nearly 40 percent. This is despite the fact that eligibility criteria have not substantially changed since the Program began. Therefore, it would appear that the informal network that refers potential candidates to the Program has gotten better at identifying children who meet standards for Program participation.

The overall combination of these four trends would suggest that the increase in Special Populations Program clients is due to demographic and referral factors which are outside the control of the Program. Even if the eligibility criteria used since the Program's start, and now established in state law, remain unchanged, further increases in the Program size are likely. There is insufficient information to predict whether the rate of growth will continue at the pace of the last six years, speed up, or slow down. The more modest growth of the last two years may suggest a slowing but it is difficult to predict. Further monitoring of the trend in Program growth rates will be important.

SECTION THREE

THE SPECIAL POPULATIONS SERVICE SYSTEM

This section of the report describes the service system currently in place to meet the needs of Special Populations clients. The service system is composed of a state level administrative organization that works in partnership with local level mental health organizations to assure the delivery of appropriate services to all Special Populations clients. This partnership is supported with some state-provided services for extremely high-end clients. Noteworthy of comment in this section is:

- a description of the service system and
- an explanation of service coordination and planning for individual children.

A. Description of the Service System

The Department of Health and Human Services (DHHS) and the Department of Public Instruction (DPI) share the responsibility to provide services to the children who are determined eligible as Special Populations clients. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) within (DHHS), acts as the *lead agency* by providing direction, leadership, and “vision” to other State and local agencies and individuals, ensuring the provision of appropriate services as stipulated in State law and administrative regulations.

1. State Level Administrative System

Within (DHHS), DMH/DD/SAS, oversees the operation of the Special Populations program. DMH/DD/SAS performs a myriad of administrative and programmatic functions. Examples of these functions are:

- strategic planning;
- state level program planning;
- development and approval of plans for local systems of service;
- consultation and technical assistance to area programs and contract providers;
- determination of eligible clients;
- budget planning and execution;
- allocation and approval of funding;
- monitoring and evaluation of services at the individual and system level;
- operating and managing two secure non-medical treatment units;

- working collaboratively with the DPI Special Populations Section;
- coordinating services with relevant agencies; and
- contracting with providers or other service systems for the provision of direct services for eligible clients.

The Department of Public Instruction (DPI), is responsible for ensuring that eligible clients receive appropriate educational services as mandated by administrative regulations and/or federal and state laws governing programs for exceptional children. Within the DPI Exceptional Children's Division, the Special Populations Section exists as a separate section set aside specifically to help support Special Populations students in the Local Educational Agencies (LEAs) statewide.

A major effort underlying all of the work done by the state offices is the Special Populations Quality Improvement Process, a series of comprehensive and ongoing efforts developed by DHHS and DPI to ensure that the local service system is able to meet the changing needs of Special Populations clients. The quality improvement process entails monitoring activities that are directly connected to improvements in Program operation. The primary thrusts of the monitoring activities are directed at individual children and at the system level with part of the system level monitoring relying on aggregated data of individual children. These monitoring activities in turn are connected to efforts to improve quality in individual service planning, clinical knowledge, practice, system design, and change. Additionally, the Special Populations Program has engaged in a series of training efforts designed to improve the quality of the knowledge and skills of the people delivering professional services to clients.

2. Service Delivery System

Direct services are primarily provided at the local level. Area Programs develop, coordinate, and/or deliver services for eligible clients in their catchment areas. Where that is not possible, DMH/DD/SAS contracts with other organizations referred to as "surrogate area programs" or "surrogates" to perform those services. Presently the state arranges services with all but two of the Area Programs and contracts with private providers for services in the remaining catchment areas. Additionally, a limited number of treatment services are operated directly by the state.

2. (a) The Local Service Provider Delivery System

The local area programs or surrogates have the responsibility of developing, directly providing, and/or contracting for a variety of services to meet the diverse needs of their children. The organizational aspects of the local Special Populations system are determined at the local level with

guidance and approval from the state. Each system varies according to the size and needs of the children; internal organization preferences; geography; and the support by and preferences of the area director, area boards, county commissioners and the community at large.

Historically, area programs have been organized according to disability areas. With the advent of various changes within the mental health field, a number of area programs have moved to a cross-disability service delivery system, separated by functions rather than disability. These alternative methods of organizing and developing staff are supported by the State as long as Program clients are served appropriately.

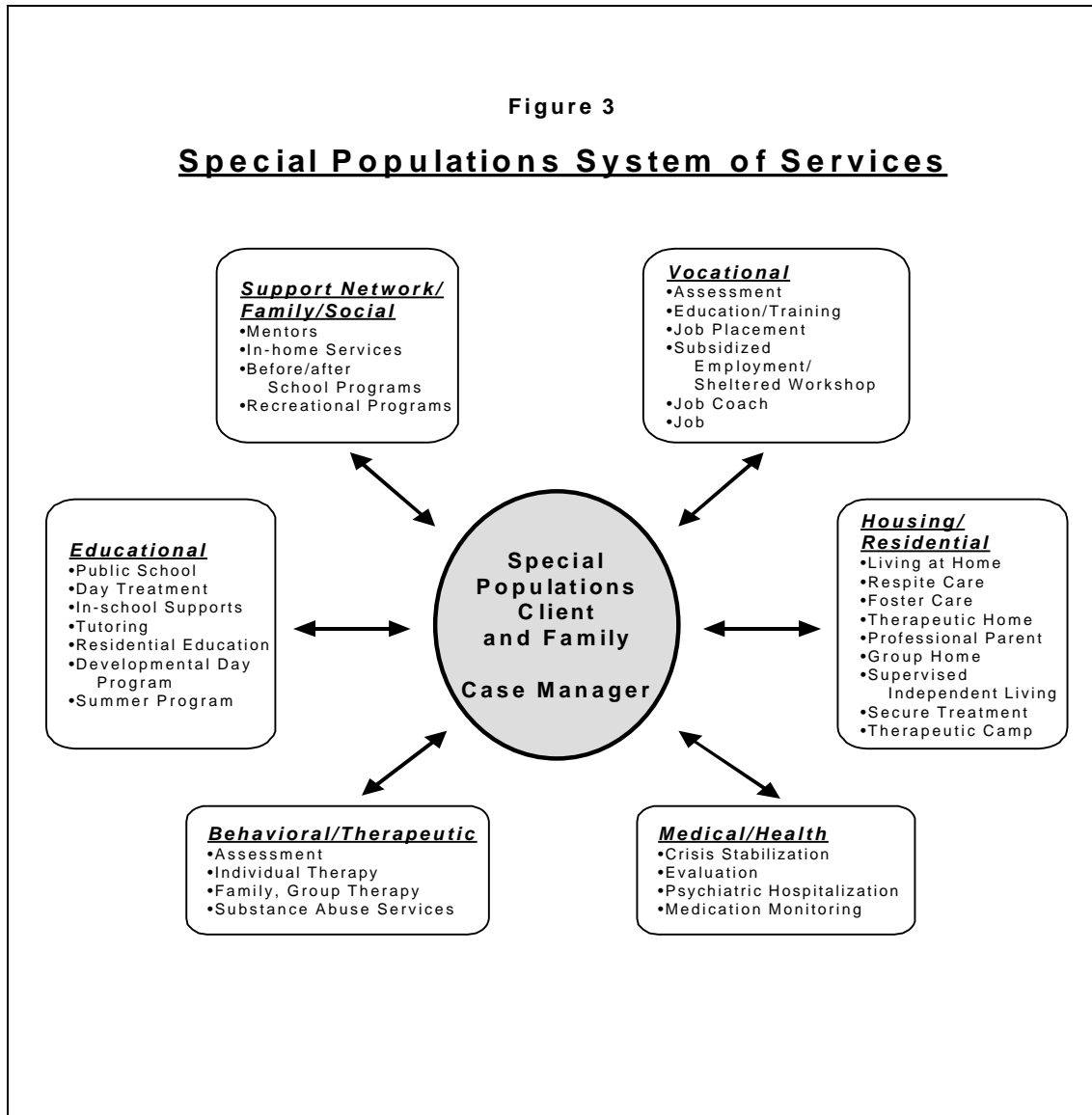
It is crucial that the Special Populations system assures the availability of a balance of services in every local system. Certain core services are always included in the service array. These core services include: case management, clinical assessment and treatment, crisis back-up and stabilization, para-professional/in-home support services, educational services, alternative family living homes and other residential services such as: group residential treatment, supervised living, secure non-medical treatment, and inpatient hospital, or at least access to these services.

Over the past six fiscal years, one of the major objectives has been the establishment of core mental health services within each area program. Some of these services are provided directly by the local area mental health program and others are available through other service providers such as the Local Educational Agencies or county Departments of Social Services. Each area program or “surrogate” organizes and structures its Special Populations Program differently and is reimbursed by the State for the services actually provided. An area program may either provide all or some of the services directly, or contract with private providers, and oversee the provision of any contracted services. If needed services do not exist within an area, the local area program develops those services within its community or secures an appropriate alternative, such as using established services in another area program or those provided by a private agency.

Special Populations services include housing, education, counseling, medical treatment, vocational training, and other social and human services (see FIGURE 3 - Special Populations System of Services). A case manager assesses the child's needs and coordinates appropriate services from a wide range of providers, including Area Programs, local school districts, or community-based private treatment specialists. The Special Populations system of services is organized around five service categories:

Figure 3

Special Populations System of Services



- **Clinical and Staff Services** - These are services, including case management, provided for a child by individual professional or paraprofessional staff in accordance with the child's individual treatment and habilitation plan. In-home services can include crisis intervention, parent training, and/or counseling for the child and other family members. Outpatient treatment services offer ways to improve or stabilize the child's family environment, to minimize the necessity for out-of-home placement, and to increase the child's family's understanding of how they can affect the child and family's developmental growth.
- **Educational Services** - The majority of Special Populations children attend regular or self-contained classes in public schools. Others require more specialized educational services, such as combined day

treatment/education, developmental day care, in-home or inpatient education or, a state-operated program. Related services include before- and after-school programs, as well as summer camps.

- **Residential Services** - There are a broad range of options for children who cannot live in their own homes. They range from structured, individual and group environments to independent living. Some Special Populations clients live in homes with specially trained staff who serve as "parent substitutes." Others who live at home are best served through respite care providers.
- **Vocational Services** - Older eligible clients (ages 16-18) may learn pre-vocational and vocational skills, including job interviewing, work values, social skills, and job skills. Some Special Populations clients have supervised work experiences - such as sheltered workshop placements, apprenticeships, and part-time jobs - that help prepare them for independent employment as adults.
- **Inpatient or Secure Services** - Some clients are best supported through short- or long-term hospitalization for diagnostic testing, medical care, and psychiatric treatment. Such placements include crisis stabilization when a child is undergoing a psychiatric or emotional episode too severe to be handled in the home. Treatment in secure (locked) settings for children who cannot be treated safely or effectively in more normalized community services is also provided.

2.(b) State Level Services Contracts

Because of the substantial infrastructure and community networks available through local area programs, it is the policy and preference of the Special Populations Branch to provide most services through local mental health agencies except in extraordinary circumstances. When exceptional service provisions are required, the state contracts with others, including private providers, for these programs. Those in current operation are:

- **Carolina Treatment Services** is under contract with the state to operate a five-bed high management group home in Guilford County.
- A contract with **Lutheran Family Services** (LFS) was established in Fiscal Year 92-93 to provide services to Special Populations clients in Johnston County.
- In Fiscal Year 94-95, the state entered into a contract with the **Institute for Family Centered Services** (IFCS) to provide services for clients from the Albemarle area. This Contract was modified during FY 2000/2001 to reflect a

change in the provider. **Pride in the Carolina's** now administers the provision of services for Eligible Assaultive and Violent Children in the Albemarle region of the state.

2. (c) State Level Provided Services

In addition to the local provider delivery system, there are a limited number of services operated directly by the state. These are:

- **Butner Adolescent Treatment Center (BATC)**, a secure non-medical treatment facility serving 12 Special Populations clients who require a locked environment in order to participate in appropriate services. The Center opened in February 1992 and operates in four wards of John Umstead Hospital. A school program is included in the program structure.
- **Oakview Supervised Apartment Program** also located on the Umstead campus. Oakview was opened by the state in October 1993 and consists of five apartments capable of housing up to 12 clients. Oakview has 24-hour staffing and provides a transitional residential program for clients leaving secure treatment, institutions, training school or other settings and who may not be ready for full re-integration back into the community. Clients served at Oakview receive their education at BATC, local schools, or adult education programs through the local community college. Vocational programming and training are key competencies for older eligible clients. The clients in this Program remain under a North Carolina General Statute 122C mental health commitment.
 - (In 1999-2000, the BATC and Oakview Programs are to be combined with the Whitaker School, also in Butner, to form one administrative unit.)
 - **Eastern Adolescent Treatment Program (EATP)**, a program modeled after BATC. EATP opened in September 1995 at the North Carolina Special Care Center in Wilson. EATP is an 8-bed, secure non-medical treatment facility. The *North Carolina Special Care Center*, part of the state system of services, administers this Program.

B. Service Coordination and Planning for Individual Clients

Meeting the needs of the individual child continues to be the primary aim of the Special Populations Program. Accordingly, each client has an individual plan developed to address specific treatment issues and a case manager who coordinates the range of services necessary to meet the child's needs.

1. The Individualized Planning Concept

Individualized planning and care are the heart of the Special Populations service delivery system. Planning for each client's treatment/habilitation is accomplished under the direction of a case manager through the development of an individualized Treatment/Habilitation Plan (T/HP). Each child is required to have a T/HP that is reviewed whenever the individual client's needs and/or circumstances change or at a minimum, annually.

Special Populations case managers have the primary responsibility for seeing that T/HPs for their clients are completed, monitored, and updated as necessary. However, they do not do this planning and monitoring alone. They work as a team with the client and the client's family, clinicians, educators, representatives from other agencies, court officials, and others to develop the client's T/HP. The planning process focuses on the strengths of the child, his or her preferences, and the child's needs to develop a set of desired outcomes based on the individual child's situation. Using the desired outcomes, a set of strategies and interventions is put together to provide a clear set of actions and steps to guide a client's team members in assisting the client to achieve his goals. The plan, along with assigned responsibilities, is used by the case manager to monitor what the child is doing and act as an advocate over time within and outside the service system to ensure that client's needs are being met and progress is being made toward the individual client's goals.

2. Case Management in the “System of Services”

Case management is the core mechanism around which the complex system of services operates. Case managers are pivotal to the successful operation of Special Populations services. An individual case manager is assigned to every Special Populations client. This individual assumes the lead role in coordinating the child’s treatment and other services. Their responsibilities include planning, coordinating, documenting, and monitoring services provided to a child and his/her family/guardian or custodian as well as serving as an agency advocate for the child, particularly with regards to service development and acquisition.

Area programs typically also have an individual person designated as the Coordinator of Special Populations services in the catchment area. This person acts as the liaison to the State Special Populations Branch and is responsible for managing and monitoring the local service system. This person may or may not have other responsibilities within the local agency system.

The framework for delivery of Special Populations services is the “system of services” model. This schema calls for a broad array of services to be used in the treatment of the Special Populations population. Reliance on a holistic approach to treatment and service delivery allows the case manager to include recognition of the medical, psychological, social, behavioral, educational, vocational, residential and legal aspects of a child’s life. Special Populations clients have multiple needs that span a variety of services, agencies, community arenas, and systems. Case Managers work with their local service systems to effectively respond to the changing needs of the clients for whom they are jointly responsible.

SECTION 4

EXPENDITURES FOR THE SPECIAL POPULATIONS PROGRAM

This section of the report describes the costs of providing services to Special Populations clients. The section provides information on:

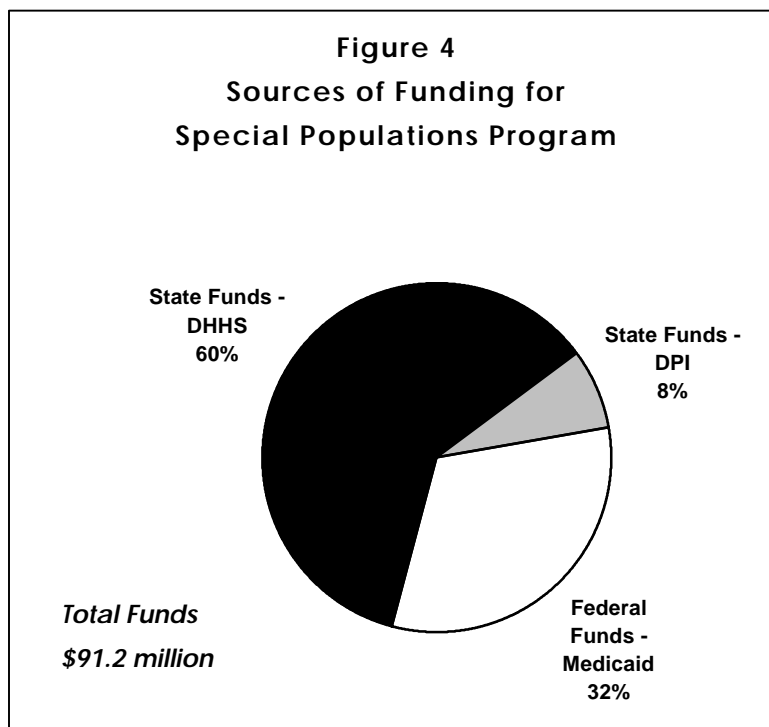
- Special Populations Program funding and expenditures,
- average expenditures for Special Populations children,
- waivers of cost rules, and
- other State funds spent on Special Populations children.

A. Special Populations Program Funding and Expenditures

In Fiscal Year 1998-1999, \$91.2 million was spent in the Special Populations Program. This includes State-appropriated funds and federal Medicaid dollars. The totals for the Program, however, do not include other state expenditures on children in the Special Populations Program that were not part of the Program's operation such as general education funds or expenditures for juvenile detention.

1. Sources of Funding for the Special Populations Program

Of the total \$91.2 million spent on the Special Populations Program in FY98-99, two-thirds, or 68 percent, was from state appropriations (see FIGURE 4). The majority of funds, \$55.2 million, or 60 percent, were state appropriations earmarked for the Special Populations Program through the Department of Health and Human Services (DHHS). An additional \$6.9 million, eight percent of the total, came from state funds appropriated to the

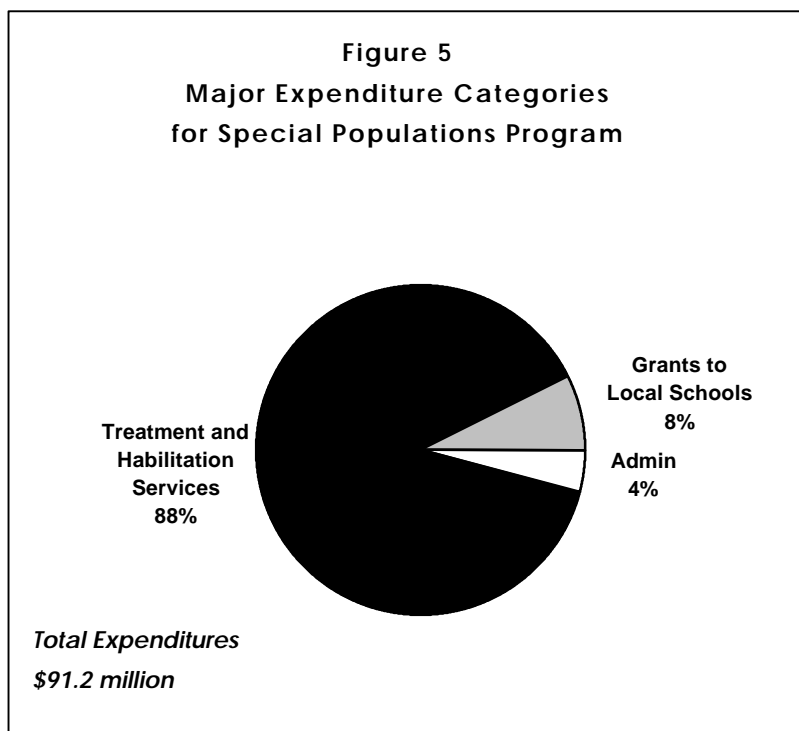


Department of Public Instruction (DPI) as a portion of the Special Populations Program. Federal Medicaid funds accounted for \$29.1 million or roughly one-third of Program funds. Much of the overall Program expenditure growth has been achieved by greater use of federal dollars.

2. Expenditure Categories for the Special Populations Program

Of the total expenditures in FY98-99, \$80.6 million, 88 percent, was for DHHS treatment and habilitation services such as case management and residential services appropriations (see FIGURE 5). DPI money, \$6.9 million, accounted for eight percent of the total and was distributed in the form of grants to local school districts for services provided to Special Populations children.

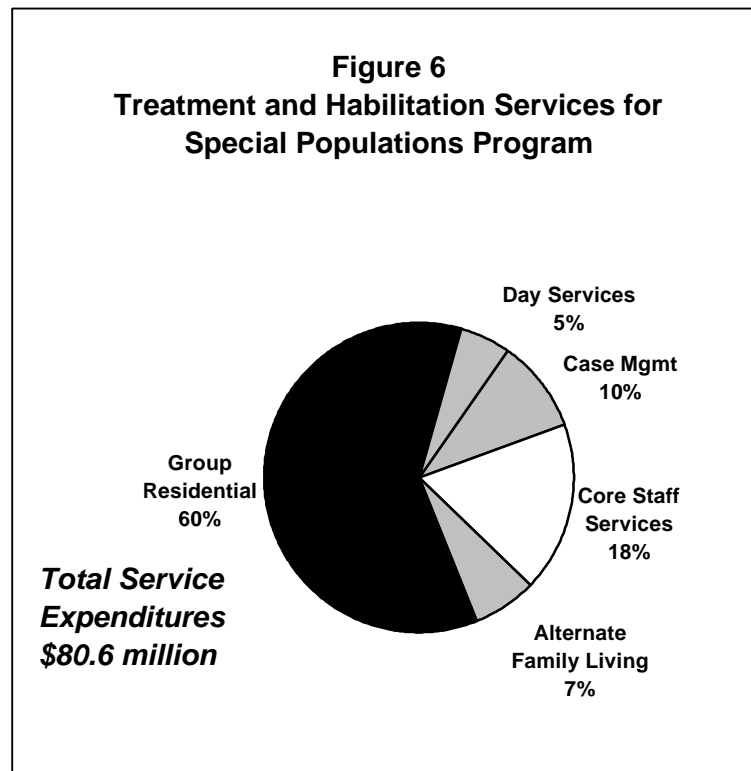
Administrative costs for the Program totaled \$3.7 million, four percent of the total, with one-fourth of that amount coming from federal Medicaid dollars.



2 (a). Treatment and Habilitation Services Expenditures

Treatment and habilitation services are the largest category of the Special Populations Program expenditures. During FY98-99, these services cost a total of \$80.6 million, an increase of three percent from the prior fiscal year. This total includes state expenditures and federal Medicaid dollars. Treatment and Habilitation Services Expenditures can be divided into five functional subcategories: case management, core staff services, alternate family living, group residential, and day services (see FIGURE 6). Residential services - group residential and alternate family living - are the major expense categories. They represent two-thirds of Special Populations Program service expenditures. Group residential services represent the largest set of costs and are used for children who require more intensive monitoring or who cannot live at home. For FY98-99, group residential expenditures represented 60 percent of total treatment and habilitation

expenses. Alternate Family Living represents additional residential services including respite care, foster care, and other alternative family living arrangements and totaled 7 percent of all of the treatment and habilitation costs. Core staff services represent both outpatient treatments such as counseling and paraprofessional services designed to help the child meet his/her particular needs.



As described in the Service Delivery System section, the Special Populations system of services is provided through local area mental health programs. The actual costs of providing treatment and habilitation services vary by program and by the providers that are used. Further detail about expenditures by service category and the average costs of providing the services in Fiscal Year 1998-99 can be found in TABLE 8. The expenditures in the table include state appropriations and Medicaid funds. The average unit cost for each service is simply the total expenditures divided by the total number of units provided. As can be seen in TABLE 8, the cost for particular services can vary with the highest payment frequently being two to four times higher than the lowest payment. However, most payments tend to be near the average. Unless granted cost waivers, all providers are required to stay within state rates.

TABLE 8
SPECIAL POPULATIONS PROGRAM SERVICE EXPENDITURES AND UNIT COSTS
FOR FISCAL YEAR 1998-99

Service Component	Number of Providers	Total Expenses	Total Units	Average Payment	Range of Payments	
					Minimum Payment	Maximum Payment
Case Management		\$7,739,655				
Case Management	41	\$4,150,462	94,206	\$44.06	\$29.27	\$48.90
Case Mgmt Support	41	\$3,589,193	80,922	\$44.35	\$28.50	\$48.90
Core Staff Services		\$14,335,684				
Outpatient Treatment	65	\$2,634,257	45,213	\$58.26	\$47.58	\$95.00
Outpatient Support	49	\$2,178,255	37,243	\$58.49	\$7.40	\$90.00
Outpatient-Group	18	\$90,591	5,832	\$15.53	\$9.96	\$40.00
HRI Periodic	39	\$1,928,844	84,654	\$22.79	\$2.35	\$28.85
HRI Periodic Support	14	\$321,927	12,335	\$26.10	\$23.48	\$28.85
HRI-Periodic-Group	12	\$89,987	9,703	\$9.27	\$6.24	\$9.62
Para-Professional	61	\$6,087,185	253,770	\$23.99	\$13.77	\$31.06
Para-Profess. Support	34	\$1,004,638	41,220	\$24.37	\$8.44	\$31.32
Alternate Family Living		\$5,533,596				
Respite Care	28	\$230,855	3,508	\$67.47	\$56.79	\$130.00
Alternative Family	52	\$5,302,741	62,269	\$85.16	\$49.35	\$173.84
Group Residential		\$48,633,034				
Group Home-Moderate	6	\$250,931	1,487	\$168.75	\$168.75	\$168.75
Group Home-High	71	\$18,026,732	76,103	\$236.87	\$136.42	\$351.00
Group Living-Secure	3	\$4,722,934	11,001	\$429.32	\$282.35	\$679.10
Group Living-Special	5	\$599,716	4,386	\$136.73	\$44.27	\$178.20
Crisis Stabilization	5	\$76,975	453	\$169.92	\$70.32	\$397.21
Residential Treatment	56	\$19,660,937	67,527	\$291.16	\$198.65	\$442.80
Wilderness Camps	6	\$1,720,036	9,164	\$187.69	\$75.00	\$300.00
Inpatient Hospital	23	\$1,603,959	4,628	\$346.58	\$173.85	\$509.00
Secure Medical	8	\$1,970,813	6,009	\$327.98	\$123.52	\$367.20
Day Services		\$4,356,356				
Day Treatment	30	\$3,847,437	157,060	\$25.88	\$3.38	\$36.91
Vocational Education	3	\$20,132	467	\$5.39	\$5.11	\$7.53
Vocational Placement	7	\$317,486	13,014	\$17.04	\$15.90	\$17.16
Before/After School	7	\$96,439	4,488	\$16.99	\$12.00	\$19.67
Special Summer Program	10	\$74,862	9,570	\$7.90	\$3.94	\$10.28
TOTAL		\$80,598,324				

2 (b) Educational Expenditures

The Department of Public Instruction Special Populations funds are designated as “add-on” funds. The Local Educational Agency (LEA) requests

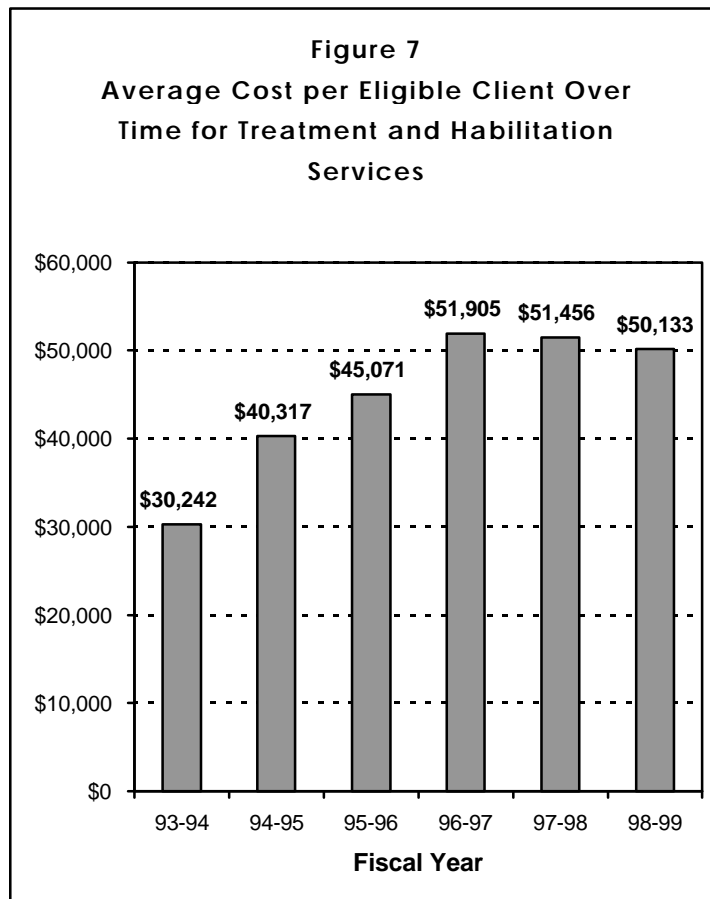
funding to supplement and strengthen services for the most difficult to educate Special Populations clients. Initial allocations are made in August, with adjustments made throughout the year. The state's total allocation was \$6,918,477, an increase of 14 percent over the prior fiscal year allocation of \$6,060,683. The allocations by LEA are shown in TABLE 9. Along with the allocations for Fiscal Year 1998-99, TABLE 9 also shows the number of children being served as of June 15, 1999. For LEAs that show students but no allotment, no funds were requested.

TABLE 9--DEPARTMENT OF PUBLIC INSTRUCTION SPECIAL POPULATIONS ALLOCATIONS TO LEAs, FISCAL YEAR 1998-99					
LEA	Allotment	Students	LEA	Allotment	Students
Alamance	89,368	16	Iredell-Statesville	23,475	9
Alexander	35,850	3	Mooreville City	0	1
Alleghany	22,836	2	Jackson	77,340	11
Anson	0	5	Johnston	151,695	25
Avery	24,202	5	Lee	52,641	15
Beaufort	67,541	9	Lenoir	109,000	32
Bertie	9,461	1	Lincoln	43,150	10
Bladen	26,475	3	Macon	11,600	4
Brunswick	72,046	4	Madison	10,556	1
Buncombe	169,511	27	Martin	0	2
Asheville City	163,709	13	McDowell	56,936	7
Burke	121,536	11	Charlotte-Mecklenburg	505,339	125
Cabarrus	60,411	12	Mitchell	8,509	3
Kannapolis City	102,120	5	Montgomery	0	2
Caldwell	183,530	23	Moore	80,685	25
Camden	17,230	5	Nash	157,831	12
Carteret	0	4	New Hanover	129,411	28
Caswell	0	2	Northampton	0	2
Catawba	0	10	Onslow	110,247	16
Hickory City	26,573	2	Orange	50,525	8
Newton-Conover City	33,209	1	Chapel Hill/Carrboro City	8,580	5
Chatham	16,026	5	Pamlico	0	2
Cherokee	29,542	5	Elizabeth City/Pasquotank	36,898	8
Clay	0	1	Pender	0	4
Cleveland	67,584	10	Perquimans	13,030	2
Shelby City	0	4	Person	86,725	14
Columbus	18,240	1	Pitt	155,613	22
Whiteville City	39,909	3	Polk	13,791	1
Craven	51,828	10	Randolph	63,366	12
Cumberland	412,440	103	Asheboro City	39,007	6
Currituck	0	1	Richmond	36,790	10
Dare	35,991	1	Robeson	208,465	56
Davidson	65,984	13	Rockingham	108,222	20
Thomasville City	4,665	2	Rowan-Salisbury	39,597	25
Lexington City	71,434	13	Rutherford	15,190	9
Davie	38,269	4	Sampson	17,090	3
Duplin	59,294	4	Scotland	0	9
Durham	177,797	39	Stanly	0	9
Edgecombe	66,639	4	Stokes	0	3
Winston-Salem/Forsyth	145,375	24	Surry	11,600	9
Franklin	0	9	Elkin City	0	1
Gaston	168,206	36	Mount Airy City	9,657	2
Graham	48,219	6	Swain	17,474	1
Granville	52,825	17	Transylvania	5,001	2
Guilford	357,841	70	Union	167,070	55
Halifax	72,301	6	Vance	87,984	24
Roanoke Rapids City	0	1	Wake	259,121	62
Weldon City	0	1	Warren	5,800	4
Harnett	10,338	13	Watauga	23,812	2
Haywood	35,245	9	Wayne	243,045	52
Henderson	123,500	14	Wilkes	42,173	3
Hertford	44,635	2	Wilson	50,664	13
Hoke	38,589	7	Yadkin	31,186	5
Hyde	17,090	1	Change for Youth Carter	47,172	3
Total for State	\$6,918,477	1,398			

B. Average Treatment Costs for Special Populations Children

Using the average daily caseload of clients served, the adjusted average cost per client was \$50,133 in FY98-99. During FY98-99, the Special Populations Program served a total of 1,964 children, but the average daily caseload was 1,607.7

clients. Many of the Special Populations children served in a year are only eligible for service part of the time because they either were newly eligible for services or “aged out” when they turned 18 and were no longer receiving services. FIGURE 7 shows the historical trend for the last six fiscal years using the adjusted average which accounts for the time clients were actually eligible for services. As can be seen, the average cost per client actually declined slightly for the second year in a row. While the decline is modest, just two percent, these two back to back declines follow a number of years where average cost per client increased substantially each year.



As in previous years, there is a wide variation in actual costs per client served. While the cost of serving most of these at-risk children is not high, a sizable number of clients are very expensive to treat. TABLE 10 divides the children into five groups according to the total amount of treatment and habilitation expenditures made for the fiscal year. This table does not include educational expenditures because the DPI grants are made to the local education agencies for the provision of supplemental services which are not all specific to individual children. The first group of children in TABLE 10 are those for whom total program expenditures totaled less than \$25,000 or less than half of the adjusted statewide average. This group of children

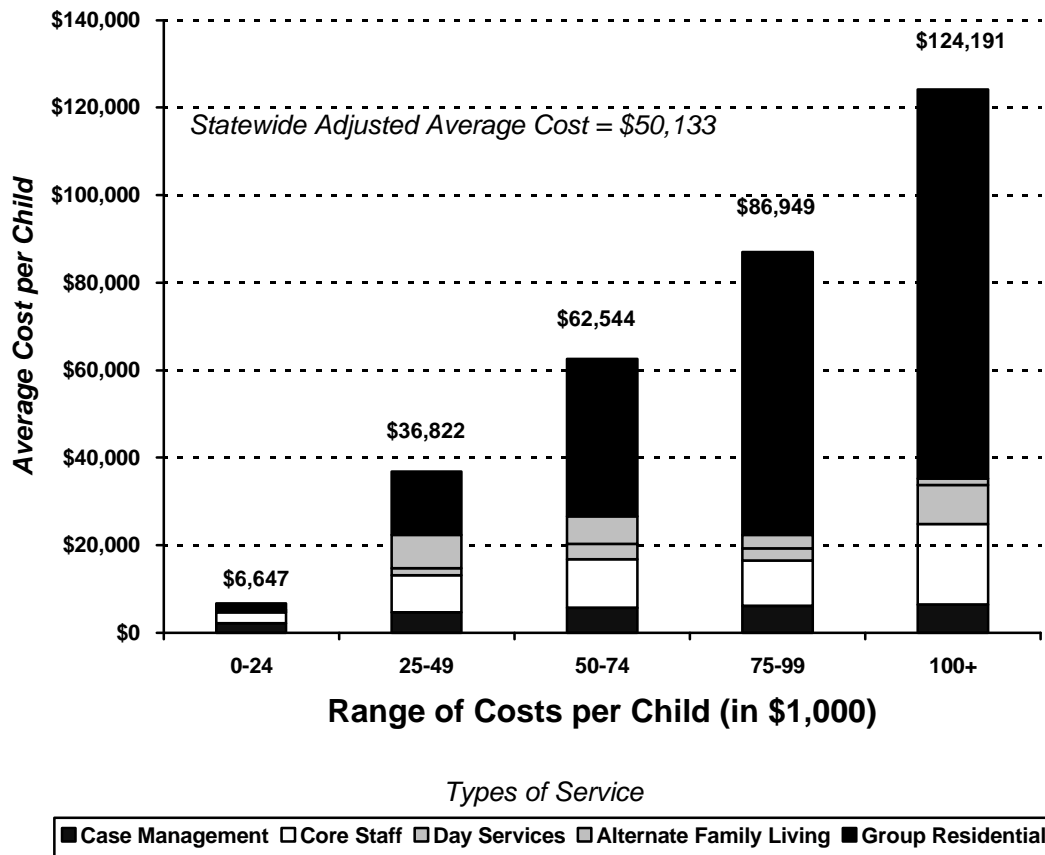
represented 47 percent of the kids served in FY98-99. The average cost of serving these children was \$6,647. This amount is low in that it reflects a number of clients who received services for only part of the year. The first three categories of clients in TABLE 10 represent all those children whose cost was below 150 percent of the statewide average cost, a legislatively defined standard for defining high-cost cases. Thus, 78 percent of the total number of children served were below the 150 percent standard or \$75,000. This distribution is very similar to the prior fiscal years.

<p style="text-align: center;">TABLE 10</p> <p style="text-align: center;">COSTS OF TREATMENT AND HABILITATION SERVICES</p> <p style="text-align: center;">FOR SPECIAL POPULATIONS CLIENTS FOR FISCAL YEAR 1998-99</p>					
Range of Costs (in \$1,000)	Number Of Children	Percent of All Children	Total Expenditures (in millions)	Percent of All Expenditures	Average Cost per Child
0-24	930	47.4%	\$ 6.2	7.7%	\$6,647
24-49	352	17.9%	\$13.0	16.1%	\$36,822
50-74	255	13.0%	\$15.9	19.8%	\$62,544
75-99	202	10.3%	\$17.6	21.8%	\$86,949
100 +	225	11.5%	\$27.9	34.7%	\$124,191
State Total	1,964	100.0%	\$80.6	100.0%	\$41,038
State Average Adjusted for Time in Program	1,607.7 (average caseload)		\$80.6		\$50,133

The large differences in average cost per child are primarily a function of the degree to which a child requires residential services as part of his/her treatment. FIGURE 8 shows bars representing each of the five groups of children by range of costs found in TABLE 10. The graph shows the average amount spent by type of service for each of these categories. The first group, whose total costs were less than \$25,000, used small amounts of all services. It is important to remember that this group includes many children who only received services for part of the year. For the other four categories of children in FIGURE 8, the most important difference between them is the amount spent on group residential services. While there are variations in the amount of the other types of services, it is the level of group residential services used that most accounts for why certain children become high-cost clients. Residential services are more intensive and more expensive than community support services. The children who require group residential services have higher needs, particularly intensive monitoring. This high-cost group also uses core staff and day services at more than twice the State average. This higher level of supervision is needed for the child, the child's family, and the community.

Figure 8

**Average Cost per Child by Range of Costs
for Special Populations Program for Fiscal Year
1998-1999**



Thus, requirements for safety and supervision of high-risk children are primary determinants of cost in the program. It is critical to realize that these particularly high-risk and thus high-cost children have such pressing needs that even if the Special Populations Program were not in place, these children would still require state expenditures through psychiatric hospitals and juvenile or adult correctional facilities.

SECTION 5

PROGRESS AND FUNCTIONING OF SPECIAL POPULATIONS CLIENTS

This section of the report describes the level of functioning of current Special Populations children and the progress they have made. Information is provided about:

- overall patterns of progress in outcomes and
- functioning and progress in seven different areas.

A. Overall Patterns of Progress for Special Populations Clients

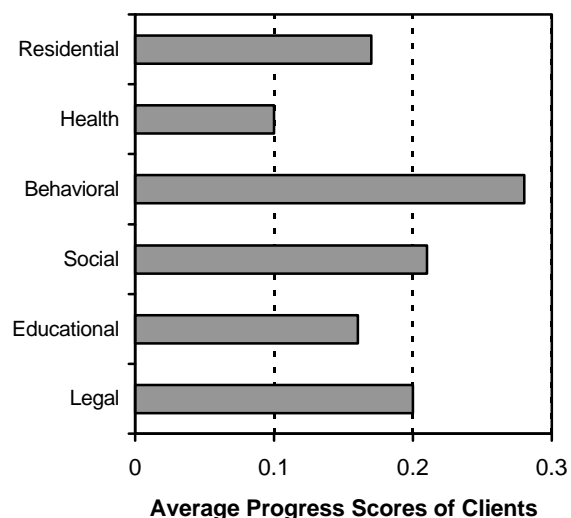
The effort to assess functioning and progress on an ongoing basis for the Special Populations clients is unmatched either in the state or around the nation. Over the last few years, the Special Populations Program, with the support of the General Assembly, has invested in the development and implementation of an extensive system to monitor outcomes and progress of Special Populations children. An extensive amount of information is collected at various times by using various survey instruments. The Special Populations Program continues to move forward in both the scope and sophistication of use of collected information to monitor and improve services provided to Program clients.

When viewed from a broad perspective, several key findings stand out with respect to the patterns of progress being made by Special Populations clients as a group.

- **Progress is Evident in All Critical Areas**

The Special Populations Program assesses functioning and progress in key domains or areas. Based on the available assessments, in all of the key areas, some progress has been made between the clients' initial assessments and their most recent ones for the Program clients as a group. As can be seen

Figure 9
Key Areas of Progress



in FIGURE 9, the areas where progress is most evident are in the behavioral, social, and legal domains. Assessment questions have possible answers ranging from 1 to 5, with 5 indicating no problems and 1 being serious problems. The measures of progress reported here are averages for all program clients of the differences between their most recent assessment scores and their initial assessments. Thus, if on the first assessment, the average score was 3.5 and on the most recent assessment the average score was 3.7, the group average measure of progress would be 0.2. A positive number indicates a higher score on average at the most recent assessment and thus progress. It is possible to have negative numbers which would indicate regression, though for the group of clients as a whole, there were no negative numbers on these overall measures. Even though the amount of progress was not striking in some areas, none showed a decline. Even just stabilizing these children is an important achievement, as many would likely continue to decline in functioning without significant intervention. But progress is being made as clients are being moved to less restrictive living situations, violent or aggressive behavior declines with participation in the Program, contact with legal agencies declines, and more children are remaining in school.

- **The Most Challenged Clients Derive the Greatest Benefit**

Those clients who have the lowest assessments when they enter the program make the most progress. In every area of assessment, those children making the most progress began the program with the worst problems. These were the clients most likely to be hurting others or themselves, living in locked facilities, with no social support, failing at school, or getting in trouble with the law. Encouragingly, the consistent pattern of the greatest progress being achieved by the group with the worst problems across all areas suggests that progress can be made with even the most difficult cases.

- **Progress Appears to Increase with Longer Program Participation**

Progress achieved in the program appears to increase with longer participation and appears to be lasting. Children who have been in the program longer show more progress than children who have been in only a short period. Furthermore, a previously completed study of children who have left the program after their 18th birthday suggests that the progress achieved is generally maintained when compared with more violent and assaultive behavior in children who were not treated. More study of clients over time will be needed, as the assessment process is still relatively new.

- **The Most Progress is Made Early in Program Participation**

The ability of the program to produce progress is greatest in the first year of program participation. By the time many of the children get referred and certified in the Special Populations Program they have been in a period of decline. The program is able to quickly turn around some of the most significant problems, whether they are behavioral or residential in nature, to

produce important change for the child early on. While improvement continues for most after the first year, progress is more difficult to achieve.

- **Program Participation Does Not Solve All Problems**

While progress is being made for these troubled children as a group, it is clear that participation in the program does not totally eliminate aggressive and non-social behavior for all of these children while still clients or after aging out of the program. Some children fully participating in the program still assault or threaten others, abuse drugs or alcohol, and get in trouble with the law. The program does not cure these children or completely eliminate socially unacceptable behavior. Progress will always have to be measured in modest but clearly positive steps forward.

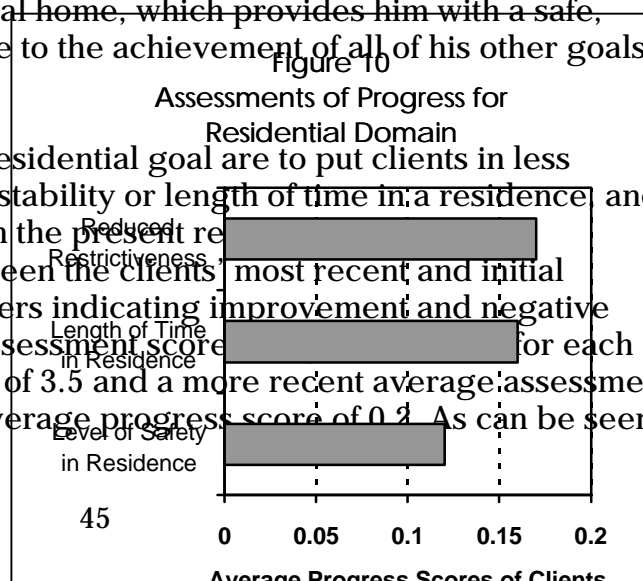
B. Assessment of Special Populations Children's Progress by Dimension

As noted in the introductory section to this report, the Department of Health and Human Services (DHHS) and the Department of Public Instruction (DPI) have a statement of desired outcomes for Special Populations children to achieve by the time they reach age 18. As part of the effort to assess desired outcomes for Special Populations clients, six dimensions or domains of desired outcomes were developed: Residential, Health, Behavioral, Social, Educational, and Vocational. These domains are consistent with those adopted by DMH/DD/SAS for all clients of the mental health service system. A seventh domain, Legal, was added due to the frequency with which Special Populations children have contact with the juvenile or adult justice system. Following are brief highlights describing how these children are functioning and progressing along these seven outcome domains.

1. Residential Domain

The desired goal or outcome for this domain is for a client to have a "home," even if it is not his natural home, which provides him with a safe, nurturing environment conducive to the achievement of all of his other goals and objectives.

Three key aspects of the residential goal are to put clients in less restrictive settings, increase the stability or length of time in a residence, and to have a high degree of safety in the present residence. These are measured as the difference between the clients' most recent and initial assessments, with positive numbers indicating improvement and negative numbers showing regression. Assessment scores for each child, so an average initial score of 3.5 and a more recent average assessment score of 3.7 would produce an average progress score of 0.2. As can be seen



in FIGURE 10, on all three of these measures, progress is being made with the most gains being achieved in getting children into less restrictive settings. While the measure of level of safety shows less progress, the actual level of functioning is already very high with most clients already at the highest assessment of living in a residence that is always safe.

Placing children in the least restrictive environment appropriate for their needs is beneficial both for providing a supportive environment and for containing costs. Special Populations children live in a variety of settings. Based on an assessment done in the spring of 1999:

- 35 percent live at home,
- 14 percent live in alternative family living arrangements such as foster care,
- 31 percent live in group care facilities,
- 6 percent live in training school, jail, prison, or other detention facility,
- 4 percent are in secure treatment facilities, and
- the remaining 10 percent are in a variety of other settings.

Thus, half of the children are still in facilities requiring more than minimal levels of age-appropriate adult supervision. While placing children in less restrictive settings reduces expenses, this must be balanced against the safety needs of the child, family, and community. Periods of restriction are sometimes necessary to stabilize a child after which many can move to less restrictive environments.

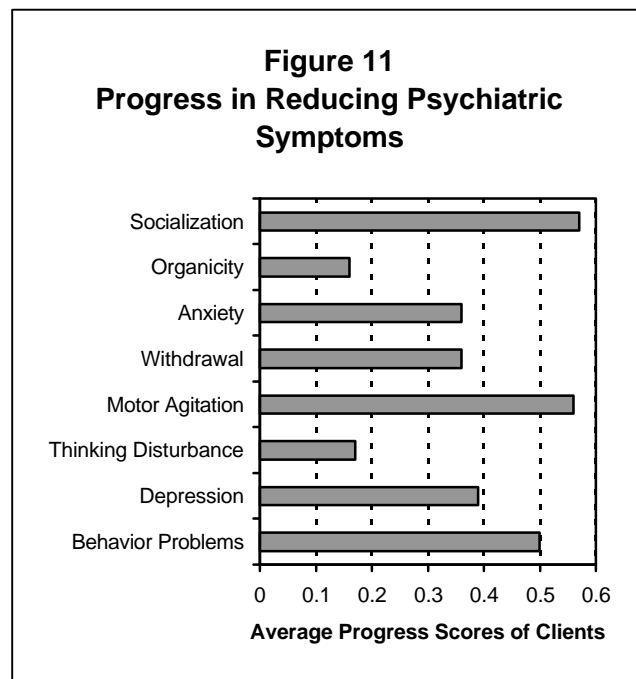
2. Health Domain

The desired outcome of the Health domain is that the client will, to the extent that he/she is able, maintain a state of health sufficient to his/her participation in normal, productive, and rewarding activities.

Most of the Special Populations clients enter the program very healthy and maintain their health over time. Those who entered with some degree of impairment from physical health problems have made large improvements early on and continued with slight gains while in the program.

Serious mental health problems are of course an ongoing concern for most of these children. Nevertheless, there are clear signs of progress here as well. As part of the ongoing assessment process, each child is evaluated using the Brief Psychiatric Rating Scale for Children (BPRS), a widely used scale to assess psychiatric symptoms of children such as uncooperativeness, hyperactivity, withdrawal, and anxiety. The average progress scores represent the difference between the most recent and the clients' initial assessments. BPRS scores can range from 1 to 7, so an average initial score of 3.8 and a most recent score of 4.4 would indicate an average progress score of 0.6. As can be seen in FIGURE 11, positive progress has been achieved in all of the eight dimensions measured by the BPRS with the greatest gains in the area of reduced motor agitation and better socialization.

The major non-mental health problem for most of these children is drug or alcohol abuse. The most recent available assessment found that 19 percent had been suspected of substance abuse in the prior three months. This represents a slight increase from the prior year where 18 percent had been suspected of substance abuse.



3. Behavioral Domain

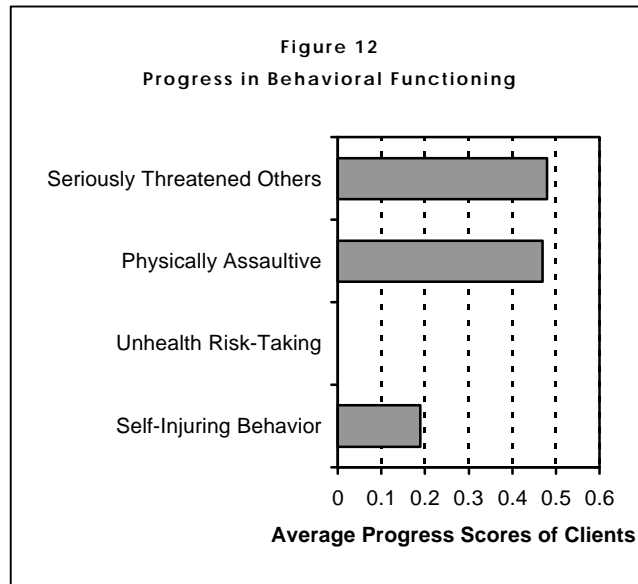
The desired outcome for this domain is that the client develop the social competence and coping skills he/she needs in order to reduce or ameliorate assaultive and aggressive behaviors.

Reducing aggressive behavior is one of the most important goals for the Special Populations children. All of these children have exhibited violent or assaultive behavior, as this is one of the key eligibility requirements for becoming a program client. Aggression is a tenacious behavior, but children admitted to the Special Populations Program improve most dramatically in this area in large part because of the emphasis placed on teaching clients behavior management skills. Reducing violent behavior is an important goal in its own right but is equally important as a precursor to making progress in other areas such as education, residential placement, and justice system

involvement. The average progress scores represent the difference between the most recent and the clients' initial assessments with positive numbers indicating progress, and negative numbers indicating regression. As can be seen in FIGURE 12, three of the four key measures for the behavioral domain show progress for clients from their initial assessment to the most recent. On average, the most recent assessment shows clients generally engaging in the behaviors less than once a month including engaging in unhealthy risk-taking behavior that showed no change.

More detailed assessments completed show several important findings. First, those children who entered with the worst behavior problems occurring more frequently than once a month show the largest improvements and are generally able to lower their violent behavior to a level equal to the children with less frequent problems. Second,

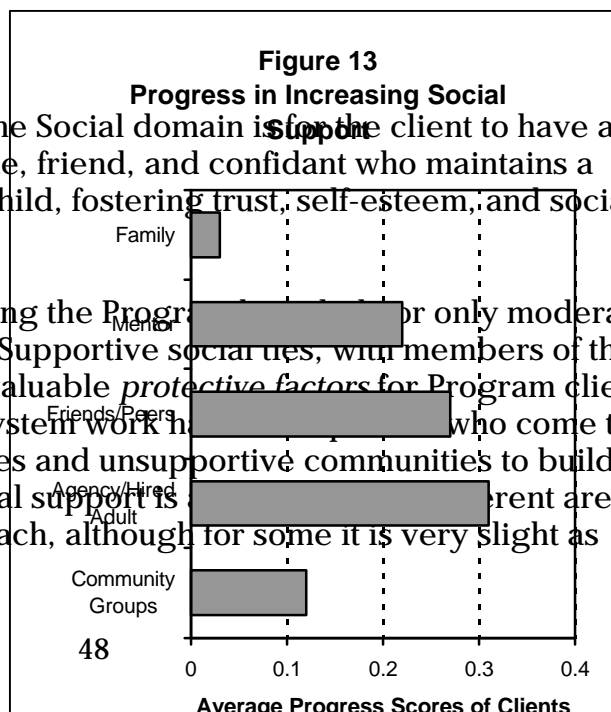
the largest improvements occur in the first year after the children are initially assessed, suggesting the changes the program puts in place can make dramatic differences early on. Finally, when looking at an array of specific violent behaviors, the longer a child stays in the program, the less frequently these behaviors occur, indicating that progress continues the longer a child is in the program.



4. Social Domain

The desired outcome for the Social domain is for the client to have at least one adult who is an advocate, friend, and confidant who maintains a long-term relationship with the child, fostering trust, self-esteem, and social competence.

Most of the children entering the Program have only moderate support from their communities. Supportive social ties, with members of their family and community, provide valuable *protective factors* for Program clients. Staff in the Special Populations system work with Program clients who come to the Program from strained families and unsupportive communities to build enduring support networks. Social support is present in all of the current areas with progress being evident in each, although for some it is very slight as



seen in FIGURE 13. Average progress scores represent the difference between the most recent assessments and initial assessments, with positive numbers indicating progress on average for all clients. Although the amount of progress is lowest for support from the family, this remains the source of the highest amount of support for clients in general. The value of supportive social ties has been consistently shown through research. The loss of community support for children who are placed outside their natural homes underscores the importance of providing alternative residential options close to home for those children who need them.

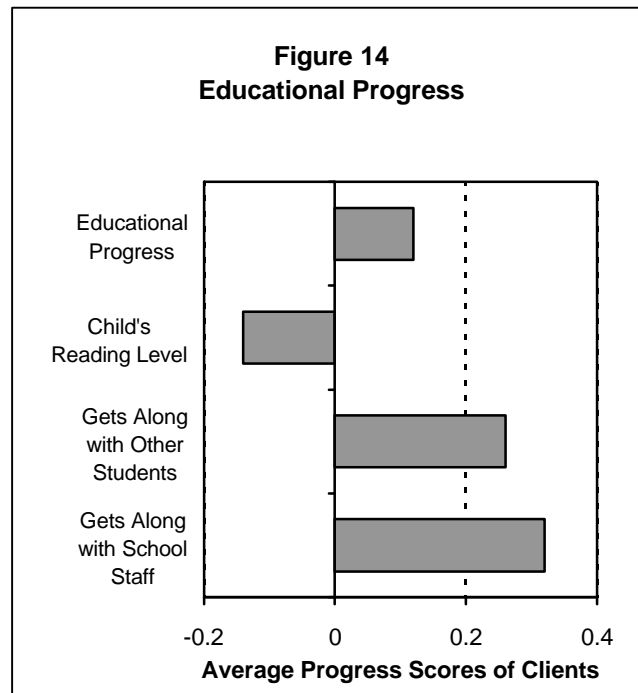
5. Educational Domain

The desired outcome of the Educational domain is that the client attends and participates in educational services appropriate to his/her needs.

Education is a difficult area for most Special Populations children. For many, developmental disabilities or emotional disorders hamper or limit their academic potential. When clients enter the program, attention to emotional and behavioral problems is often needed before school problems can be addressed. For children who have performed well in the past, addressing their problems can disrupt their schooling.

Keeping children in school is the most obvious first need, and the Special Populations Program has made clear progress here. As noted earlier in the report, six years ago approximately 68 percent of Program clients were in public schools but this proportion had grown to 84 percent as of 1999. In addition, a number of other clients are in alternative non-public schools. Based on annual assessments, for children who were not enrolled in school a year earlier, eighty percent were in school in the most recent survey. For children not enrolled at their first survey, two to four years earlier, fully 96 percent were now in school.

Most of the clients enter the Program assessed as having significant educational problems or setbacks. On average, most are roughly two grades below their expected reading level. Progress has been achieved, particularly at helping Program clients get along better with other students and teachers. This may facilitate learning later. The improvements in reducing aggressive and violent behaviors clearly translate into an



improved ability to get along with other students and school staff. As can be seen in FIGURE 14, there was regression on average for clients' reading levels from their initial to most recent assessments. This is troubling, since they start off already behind in reading ability. However, clients were judged to making some progress overall although they were still experiencing significant problems.

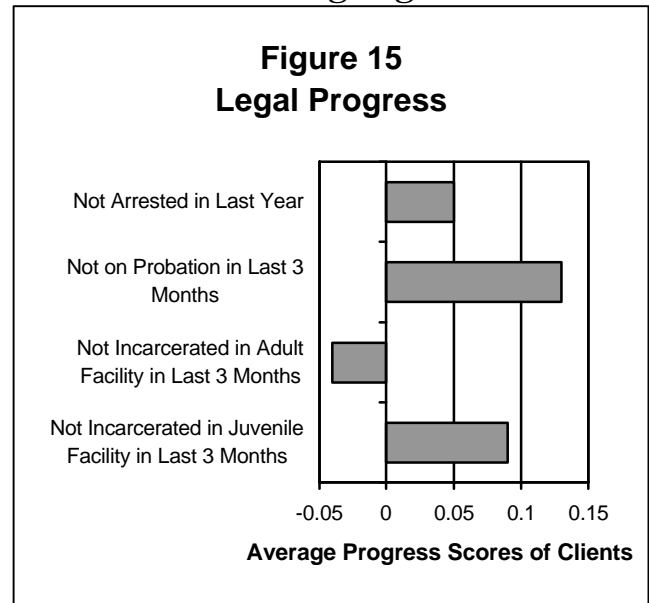
6. Vocational Domain

The desired outcome of the Vocational domain is for the client to be engaged in meaningful employment in a real work setting of his/her choice, or in activities leading toward that goal. For most children, staying in school is the key means to further the desired outcome in the vocational domain, so the progress achieved there is important. However, some children are not in school for a variety of reasons or choose to engage in work. Based on a complete survey of clients in the spring of 1999, 13 percent of the Special Populations children were gainfully employed and earning money for their work. Given that current employment is not a primary goal and that more than half of the clients being served are under the age of 16, the small percent who are employed should not be seen as a low number.

7. Legal Domain

The desired outcome for the Legal domain is that the child function in the community with a minimum of contact with social control agencies ranging from the police to the court system.

Since Special Populations Program eligibility requires evidence of violent assaultive behavior, contact with the law is an ongoing concern for these children. Nevertheless, most of these children manage to stay out of trouble after becoming program clients. As of assessment data for 1999, 74 percent of the children had not had any contact with law enforcement in the last three months, 89 percent had not been arrested in this time, and 91 percent had not been convicted of any crime during the three months. However, many of the children have ongoing legal problems. One-fourth of the children or 25 percent are currently on probation, 4 percent are in training school, and another 2 percent are in jail or prison.



There has been improvement in some areas of legal outcomes. Fewer are being arrested, placed on probation, or placed in juvenile detention. The average progress scores in FIGURE 15 show the difference between the most recent and initial assessments with positive numbers indicating progress. The legal scores range from 1 to 2, so the average level of progress represents the proportion of clients not having problems compared to their initial assessments. There has been regression in the numbers of clients incarcerated in adult facilities over the last three months, but as already noted, very few of the clients are in adult correctional facilities. There is no evidence that this suggests a trend of great concern at this time. Of children who had been arrested prior to entering the program, over two-thirds remained arrest-free since they started. Of the majority of clients who had not been arrested prior to entering the program, less than one-fifth had been arrested during the year prior to administration of their most recent assessment.

Across all of the key areas of concern, progress is being made in getting clients to higher levels of functioning whether that means less violent behavior, staying in school, or getting children into less restrictive residential settings. The Special Populations offices of DHHS and DPI will continue to

move forward in monitoring and analyzing outcomes to more clearly understand what helps children make progress and implement useful improvements in treatment and systems operations.

APPENDIX A

REPORT TO

***The House Appropriations Subcommittee on Health and Human
Services
and
The Senate Appropriations Committee on Human Resources***

on

***A Plan for Integrating the Willie M. Program
Into Child and Family Services
To
MAXIMIZE THE EFFECTIVENESS AND EFFICIENT USE OF
FUNDS
Appropriated for the Delivery of Willie M. Services***

**Department of Health and Human Services
Division of Mental Health, Developmental Disabilities,
and Substance Abuse Services
Child and Family Services Section**

May 1, 2000

A Plan for Integrating the Willie M. Program Into Child and Family Services

I. Reason for the Report

The General Assembly of North Carolina, Session 1999, in Session Law 1999-237, House Bill 168, Part XI, Subpart 6, Section 11.40 (d) required: *The Department shall examine State and local administration of Willie M. and Thomas S. services in order to identify organizational or operational changes that may be made and other efficiencies that may be realized as a result of dissolution of the Willie M. and Thomas S. classes. Not later than May 1, 2000, the Department shall report to the members of the House Appropriations Committee on Health and Human Services and the Senate Committee on Human Resources on the status of its compliance with this section and its proposed plans for maximizing the efficient and effective use of funds appropriated for these services in the future.*

II. Background

Willie M. was one of four children¹ on whose behalf a class action lawsuit was filed in October 1979. The plaintiffs, all minors, sought to receive treatment and educational services that had repeatedly been denied them in the North Carolina education and care system. According to their petition, each of these children had a history of violent behavior and mental or emotional handicaps and were often blocked from entering, or asked to leave, state-sponsored programs that were claimed to be not appropriate to meet their needs. The defendants were state officials including the Governor, the Secretary of the Department of Human Resources (DHR), now the Department of Health and Human Services (DHHS), the State Superintendent of Public Instruction and, the Chairman of the North Carolina Board of Education.

In September 1980, the parties agreed to a settlement in which the Defendants promised to identify and provide appropriate services to all children meeting the criteria stated in the lawsuit. The Federal Court established a *Review Panel* to monitor and oversee the State's implementation of the *Consent Decree*.

During the following years, the Department of Health and Human Services and Department of Public Instruction, with the support and assistance of the General Assembly, established a client-focused program of services across the State of North Carolina. In 1995, the General

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Assembly enacted legislation defining those clients eligible for Willie M. services and authorized the Department of Health and Human Services (DHHS) to adopt rules that govern the following areas:

¹ The term "children" applies to those between birth and the 18th birthday.

- eligibility for services
- service planning
- the responsibilities of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services
- requirements for the rendering of services through the Area Programs
- notice to parent of proposed changes in a client's Service Plan
- procedures for responding to, and resolving, disputes concerning a child's needs, the services rendered, mediation, contested case hearings, and administrative review.

In 1997, based on progress made in serving this population, DHHS petitioned the Federal Court to find the State in compliance with the 1980 Consent Decree and requested dismissal of the lawsuit. Judge Graham Mullan heard the State's petition and granted a *Motion to Dismiss* on January 22, 1998.

The dismissal of the lawsuit did not end the State's commitment to identify and serve children and adolescents with serious mental, neurological, or emotional disabilities accompanied by aggressive or violent behavior. Rather, it meant that the State now exercises its responsibility to serve these children without Federal Court oversight. Previous General Assembly actions have allowed DHHS to develop and implement a statewide-integrated system of care that appropriately provides for these children through a comprehensive system of services. Recently, the State Auditor issued a report of the findings of the study by Public Consulting Group entitled *A Study of Psychiatric Hospitals and Area Mental Health Programs*. The report describes the Willie M. program as a service model to emulate and expand upon for services to other children with serious mental health/behavioral problems.

The current challenge involves the planning, development, and implementation of an adjusted program model that will expand the reach of the service delivery system to a broader array of needful and deserving clients. "Expanding the reach" of the delivery system, means that the types of services now provided to the Willie M. population will be provided to other children with serious emotional disturbances to the extent that the resources exist to do so. The service model that should be extended includes comprehensive assessment, case management, interagency planning for treatment/habilitation and an array of intensive

treatment/habilitation services. Essentially, this model is the System of Care model that is the method of service delivery considered appropriate for all children with intensive mental health treatment needs.

DHHS proposes to reconfigure the Willie M. program and, to the extent possible, generate savings that will allow expansion of quality services to broader categories and select groups of clients without unraveling the current service delivery program.

The plan below will be implemented with caution, as it is not clear how much change is appropriate within the Willie M. services and how much savings will result.

It is clear that of the approximately 78,000 children served last year, there is a substantial number who could benefit from the proposed modifications.

- Needs Assessments over the past two years indicate that over 9,000 children are on waiting lists for intensive services; and
- Approximately 50 children are being served in out-of-state residential treatment facilities because intensive services do not exist in North Carolina.
- Monitoring of children in psychiatric hospitals who could not be discharged for lack of community services to receive them indicates that over 100 children per year are determined to be in such predicaments.

Clearly, changes in the Willie M. system will not result in sufficient savings to address all of these needs, but they will make some small contribution.

III. The Proposed Plan

Prudent management practice and the desire to comply with legislative mandate has caused DHHS to study and identify, organizational and operational changes in the Willie M. Program that will maximize the efficient and effective use of funds appropriated for these services. Implementation of the change process has already begun. The decision of the federal court to return responsibility for program operations to the state has allowed the Department to integrate the quasi-independent Willie M. Program more fully into the organizational structure of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services under the Child and Family Services Section. Additionally, the end of the lawsuit has provided the opportunity to adjust policy and fine tune procedures, in such a manner that a more efficient and effective operation may be achieved. Such actions are intended to allow DHHS to achieve its legislated mandate to expand service provision to youth other than those identified as Willie M.

DHHS plans to continue its commitment to provide quality services to children identified as Willie M. However, DHHS also realizes that there are other children with mental health needs equal to, or greater than, those found in the Willie M. population. These children have been unable to access services because the array of needed services does not exist outside the Willie M. program and because these children do not express their symptoms or problems through the violent or assaultive behavior that would qualify them for Willie M. services. Given that the Special Budget Provisions of the 1999 Session of the Legislature granted permission to expand the use of Willie M. resources, DHHS has studied the possibilities and puts forth a proposal for consideration.

As outlined below, DHHS plans to provide opportunity, incentives and technical assistance to area programs so that that they can expand services, to the extent possible, within the resources formerly designated for the Willie M. population only, to serve a greater number of children and families. The Department's goals are to

- work with all stakeholders to determine what services can be delivered to the Willie M. population in a more parsimonious fashion without reduction in the effectiveness; and
- delineate groups of children whp can access current resources and programs.

A. Results Already Achieved

Changes began on October 1, 1999 when the Willie M. Program was absorbed into the Child and Family Services Section of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Thus far noteworthy accomplishments are:

- The responsibility for the provision of vision and leadership for all child mental health services has been vested with a single administrator.
- The responsibility and authority for the delivery of mental health services to children and adolescents in North Carolina have been organized into one administrative unit.
- Staff have been integrated at a central location.
- The administration of secure non-medical treatment facilities for children has been organized under the same Section with a single admission process for all facilities.
- Whitaker School and the Butner Adolescent Treatment Unit have been consolidated into a single program under one director, and budgets will be consolidated for the next fiscal year.
- The Child and Family Service Section has been established as the principal contracting party with private providers of children's services.
- The role and functions of the Regional Service Managers are being modified to include the provision of technical assistance within the Section's System of Care initiative.
- The Child and Family Services Section of DMH/DD/SAS has initiated discussions with stakeholders to build a broad representational group to gain input into the planning process and to serve in an advisory capacity as the changes described below are implemented.

B. Next Steps in the Proposed Plan

The proposed plan is to begin with approximately 20-25 area programs that have a high volume of Willie M. children identified, as they will have more flexibility and more opportunity for savings associated with larger amounts of funds. Of

these, a smaller number, 10-12, will serve as pilot sites to test the feasibility of the changes proposed. Over a six-month period, changes will be planned between the Child and Family Services Section and these programs, with pilot efforts beginning in January 2001. If these changes prove successful, the additional 10-13 area programs will implement similar changes within a 12-month period.

Approaches for the smaller programs will require more careful study or some banding together of the services provided by smaller programs—a possibility which may occur as the recommendations of the State Auditor's report are implemented.

Based on historical use of services, including outpatient, residential, day, inpatient and other services, the participating area programs will be allocated funds on a case rate basis. The intent is to work jointly with area program leadership to establish savings within each area program that can be used to serve other similarly situated clients in the catchment area. Due to the very tight budget for current clients and the time it will take to adjust treatment plans and service patterns, we do not expect any appreciable savings in the first year of this operation. Over time, however, we believe that the incentives involved will lead area programs to take actions that can produce savings. It is anticipated that savings may be achieved by the following actions:

- concentrating service delivery around appropriate rather than optimal treatment and habilitation plans;
 - providing training and technical assistance in the use of entitlement programs, including Medicaid, Health Choice and Title IV-E of the Social Security Act;
 - partnering with other state agencies and their local counterparts to ensure that all collaborate in meeting their responsibilities to the Willie M. population;
 - clarifying with other sections within DMH/DD/SAS how responsibilities for the Willie M. population may be appropriately shared, such as using CAP-MR or Youth Substance Abuse funds to support the treatment and care needs, as appropriate;
 - establishing a mechanism through the Child and Family Services Section to review high cost cases to include consideration of the effectiveness of service plans;
 - providing clinical training in best practices for the hard-to-serve populations; and
 - reviewing record-keeping and reporting requirements to decrease local administrative costs.

Savings achieved through these and other means would be used to provide services to other high risk/high need populations of children with mental health disorders. These priority populations include:

- Children whose mental health problems are sufficiently serious to warrant placement in psychiatric hospitals or residential treatment programs; and
- Children with identified mental health problems who show substantial evidence that they will need intensive services. These populations include those who are dually diagnosed, those who need the services of multiple agencies at the same time and those who have a high number of risk factors for poor outcomes.

DHHS believes that this approach will allow an extension of services to a cross section of individuals in numerous diagnostic categories, such as:

- Children labeled as sexually aggressive youth;
- Children with serious emotional disturbance and in foster care;
- Children with serious emotional disturbances and other diagnoses, such as serious emotional disturbance and deafness; and
- Children at risk of out-of-home placement.

As savings are realized and resources are made available to these priority populations, services will be delivered through the proposed System of Care model. This model has been refined from approaches used in the Willie M. program, the demonstration project in Western North Carolina funded in 1989-94 by the Robert Wood Johnson Foundation, Carolina Alternatives, the Fort Bragg Child and Adolescent Mental Health Project and the three System of Care demonstration projects currently funded through a federal grant program.

Based on these models, specific plans will be developed to include:

Efforts to identify those clients with the greatest need for assistance through a comprehensive assessment, to include assessment of risk and resiliency factors. Case management services will be established to support attainment of the established Treatment Plan Goals.

The Child and Family staff in each area program will monitor children's progress and provide progress/outcome data to the Child & Family Services Section.

The Child and Family Services Section will provide technical assistance and support.

- The Child and Family Services Section will monitor service use and service costs through utilization review and provide on-site consultation, as needed.
- Child and Family Services Section staff and Division staff will partner to support area program effectiveness.

IV. Timelines

Many of the changes described above will be "process changes" and thus will begin and increase over time. Some are underway. As stated above, 10-12 area programs will serve as pilot sites during the next state fiscal year with the expectation that additional programs (10-13 more) will be participate in the change process over the next 18 months.

V. Changes in Administrative Rules Needed

DHHS proposes to make changes in the DMH/DD/SAS Administrative Rules in the section governing the Willie M. program (Section 7000) to allow the implementation of the plan described above. These changes will ensure that:

- The services to the Willie M. population will be delivered within annualized resources rather than the state providing an open-ended entitlement as the current legislation and rules allow; and
- The state has the authority to review plans developed by local service planning teams for appropriateness of services and reasonableness of cost.

Proposed changes to the Administrative Rules will be made with assistance from the Office of the Attorney General.

